Towards a Comprehensive Health Policy for the 1970's

A WHITE PAPER

May 1971

TOWARDS A COMPREHENSIVE HEALTH POLICY FOR THE 1970's

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U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

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FOREWORD

This White Paper lays before the American public the thoughts and processes that eventuated in the Administration's comprehensive health strategy. The White Paper is "political" in only one respect: given the choice between extending the activities of the Federal Government, and using the forces of the private sector to achieve an objective, the latter was preferred. Although "political," the choice can hardly be viewed as "partisan." Preference for action in the private sector is based on the fundamentals of our political economy—capitalistic, pluralistic, and competitive—as well as upon the desire to strengthen the capability of our private institutions in their efforts to provide health services, to finance such services, and to produce the resources that will be needed in the years ahead.

For the better part of a year, the Administration sought ideas and advice from every conceivable source—from within the Government as well as from individuals and organizations outside of the Government. No constraints were imposed upon these sources; the Administration sought the broadest range of alternatives for every identifiable problem, no matter how small or large. As a result, the Administration believes that no reasonable idea was denied a hearing.

In the winnowing process through which some options were discarded and others were retained, it became necessary to impose constraints. The President does not enjoy the luxury of considering any subject, no matter how important, in isolation. The problems of health care have to be dealt with, but so do the problems of welfare, public safety, environmental protection, national defense, and a host of others. There are no easy choices among these competing claims, no choices between "good" and "bad," but only between one good and another. Quite often, advocates of any particular public good tend to ignore the others, and thereby ignore the discipline of choosing. Yet choosing is the essence of governing.

At some point in this process, therefore, choice was inescapable—not only among the competing claims but within a context that took into account other factors as well. These other factors included projections of the Gross National Product and Federal revenues; plans to combat a sluggish economy, unemployment, and inflation; and proposals that would bring the concepts of New Federalism to life—revenue sharing, welfare reform, manpower training reform, and reorganization of the Federal Government and its intergovernmental relations.

The comprehensive health strategy, accordingly, fits within a broader strategy. The books are not irrevocably closed on alternatives: If other reasonable choices present themselves—to obtain a better distribution of health manpower, for example—they will be welcomed.

One further note. Those who have grown used to viewing health care needs within the narrow focus of specific categorical problems—problems caused by a certain disease or problems afflicting certain population groups—are likely to be disappointed by the Administration's health strategy. For, with few exceptions, the strategy seeks to modify the entire system of health care. It became abundantly clear, in the process of defining precisely the nature of the "health care crisis," that the most basic and widespread problems were in fact systemic, and that further categorical and piecemeal efforts would very likely exacerbate rather than ameliorate the problems.

In publishing this White Paper, the Administration has two main objectives in mind. The first is to contribute to the public's understanding of the issues and of the reasons that led to the Administration's choices. The second is to help to elevate the debate on a matter of crucial importance to the Nation from the domain of rhetoric and opinion to the level of thoughtful consideration and demonstrable reasoning.

Elliot L. Richardson, Secretary

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I

DEFINING THE PROBLEMS

Before the Administration would consider any specific solution to the "health care crisis," it required first a clear and precise statement of the problems—what was and what was not contributing to the crisis. The task at the outset, then, was to examine the health status of the Nation, the trends in the development of health care resources, the financing of care, and the Federal actions in each of these areas.

1. Health Status

The indices with which we measure health, it was quickly found, leave much to be desired, especially in terms of the definition of "health" the World Health Organization uses: a positive sense of physical and mental well-being. Our indices are of illness rather than of health, and statistics of death are statistics on existence, not only of health. Moreover, we lack indices of consumer satisfaction with health services received, and our measures of quality are also essentially negative and anecdotal—such as excessive surgery or over-reliance upon drugs.

With all of their inadequacies, the gross measures of health status indicate a long-term trend of improvement. A child born today, for example, can expect to live 30 percent longer on the average than a child born in 1920. Nonwhite children, while lagging behind white children in total life expectancy, have made the greatest gains—a third more life for non-white men, and more than a 50 percent increase in life span for non-white women. Although, for inexplicable reasons, the life expectancy of non-white males declined between 1967 and 1968, non-white women now have a longer life expectancy than white men.

Infant and neonatal deaths have been on the decline for sometime, and maternal death rates dropped by 66 percent between 1950 and 1967.

Days of disability have also declined in the past decade. Days lost from school or from work, as well as days of restricted activity in general, per person per year have shown a favorable trend. Bed-disability days, which had declined between 1960 and 1967, took a slight upturn in 1968.

There appear to be a number of factors contributing to these trends. Rising levels of income, which have brought with them better nutrition, housing, and clothing, higher levels of educational attainment, and general improvements in sanitation have all played a significant role. So too has

medical science in bringing a number of infectious diseases under control, in making successful inroads on some chronic illnesses, and in bringing about widespread improvements in diagnosis, treatment, and rehabilitation. There is no smallpox in the United States today, and cases of diphtheira, typhoid fever, and whooping cough are rare. The incidence of poliomyelitis, which killed or paralyzed thousands as recently as the 1950's, has been drastically reduced, and measles and rubella are being brought under control with newly developed vaccines. Among the chronic diseases, the discovery and use of drugs have dramatically changed the treatment of the mentally ill; and new methods of diagnosis and treatment have been highly successful against certain forms of cancer, rheumatic heart disease, and hypertensive heart disease.

In sum, the gross measures of health status indicated that health has been improving, not worsening, and the cause of the crisis in health care is not to be found in the general status of health.

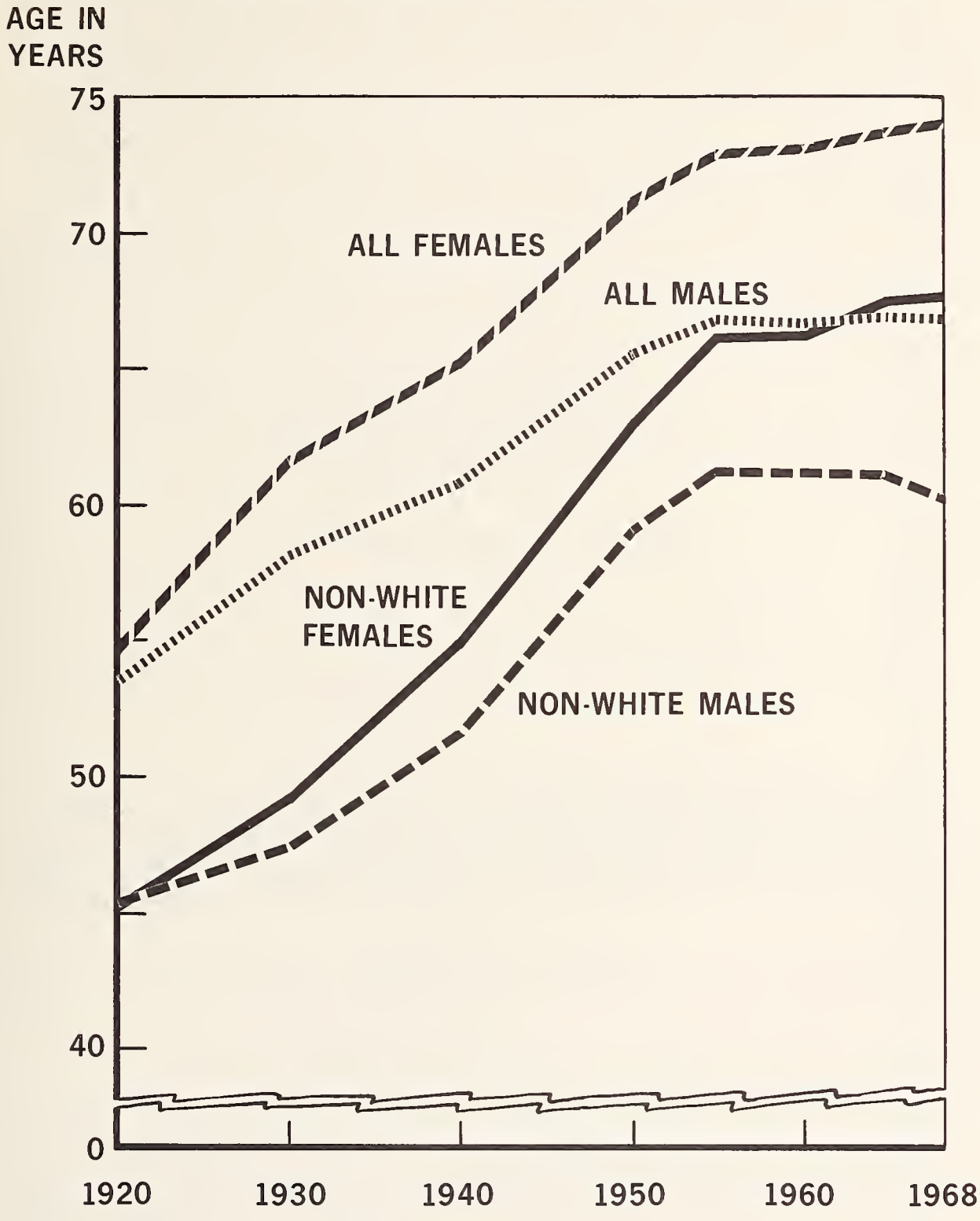
These gross measures, however, mask very large disparities in health status among sub-populations in the Nation. On nearly every index that we have, the poor and the racial minorities fare worse than their opposites. Their lives are shorter; they have more chronic and debilitating illnesses; their infant and maternal death rates are higher; their protection, through immunization, against infectious diseases, is far lower. They also have far less access to health services—and this is particularly true of poor and non-white children, millions of whom receive little or no dental or pediatric care.

Part of the health care crisis, then, is our awareness of these differences among our people—the denial to some of a life span as long and as relatively free of disabilities and illnesses as that which others enjoy—accompanied by a sense of injustice that denial entails, and by expectations that denial and its effects can and should be obviated.

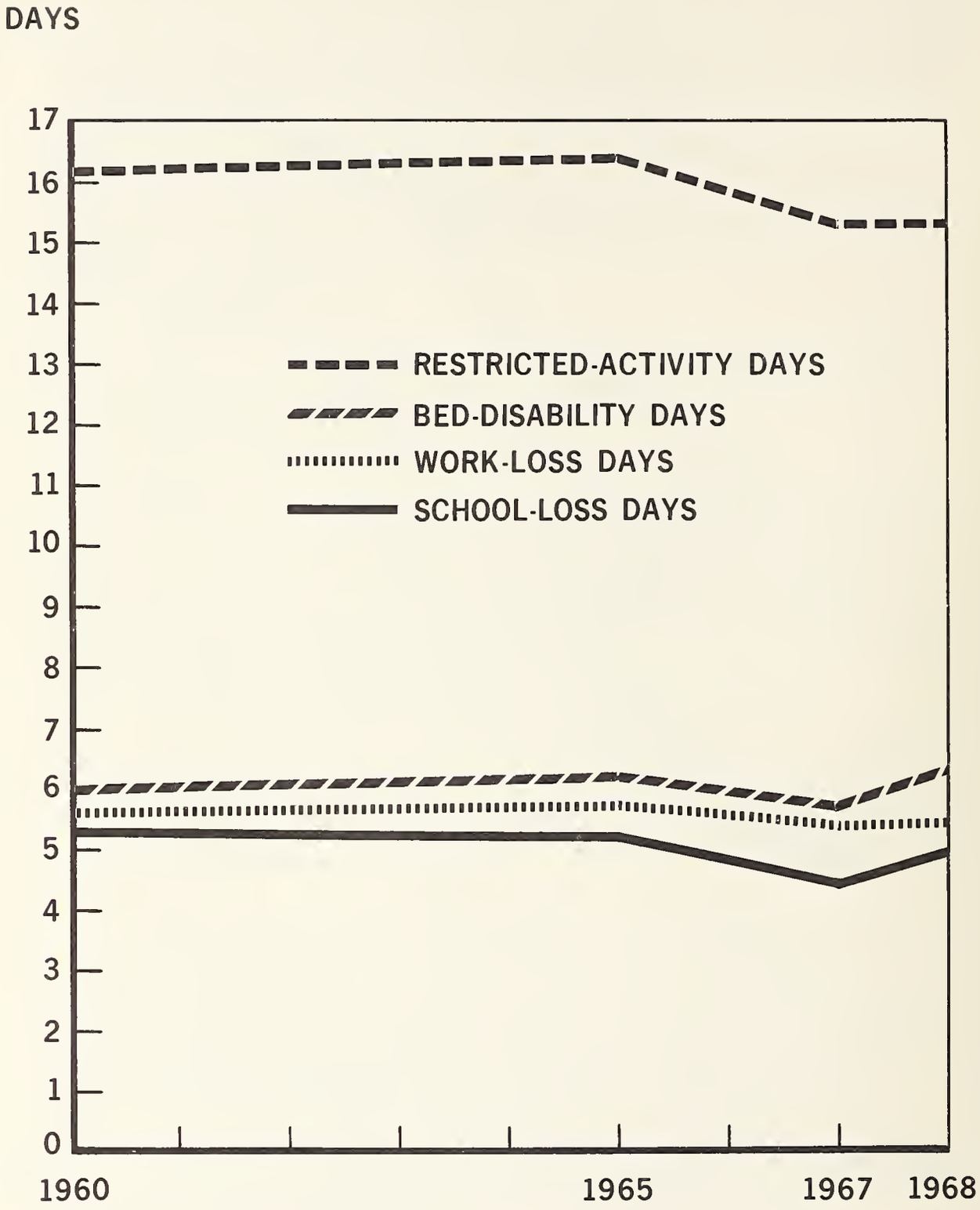
If this is an adequate description of part of the health care problem, in which race and income and related socio-economic variables are playing dominant roles, then we must begin to consider several alternatives to *medical* care to close the gap in *health* status. For at least some components of this problem, reforms in welfare, in education, and in civil liberties should pay dividends in health status.

Another type of disparity which contributes to the concern over health is the difference between the United States and other nations on several of the indices by which the national health status is measured. Once again, the comparisons are not statistically neat (definitions of "live births," for example, have varied among nations), but as gross measures they indicate that the United States is not performing as well as other advanced nations.

Expectation of life at birth, 1920 – 1968



Annual days of disability per person, 1960 – 1968



Our ranking as 13th in infant mortality rates is the key indicator of relatively poor performance. Even if all the statistical variations were straightened out, so that the rank of the United States rose to 11th or 10th, there would be little rejoicing. For the belief is that the United States, with its great abundance, should have the lowest infant death rate, and the expectations are that it can achieve that rank.

2. Health Care Resources

Health manpower and hospital facilities—the major health care resources—have been growing faster than population, especially in recent years. Excluding the military, the number of hospital beds per 1,000 people increased from 12.4 in 1963 to 13.5 in 1968. Between 1950 and 1966, while the population of the United States increased by 29 percent, the number of people in health occupations increased by more than 90 percent. In 1960, 2.9 percent of the civilian work force were in health occupations; by 1966, there were 3.7 percent.

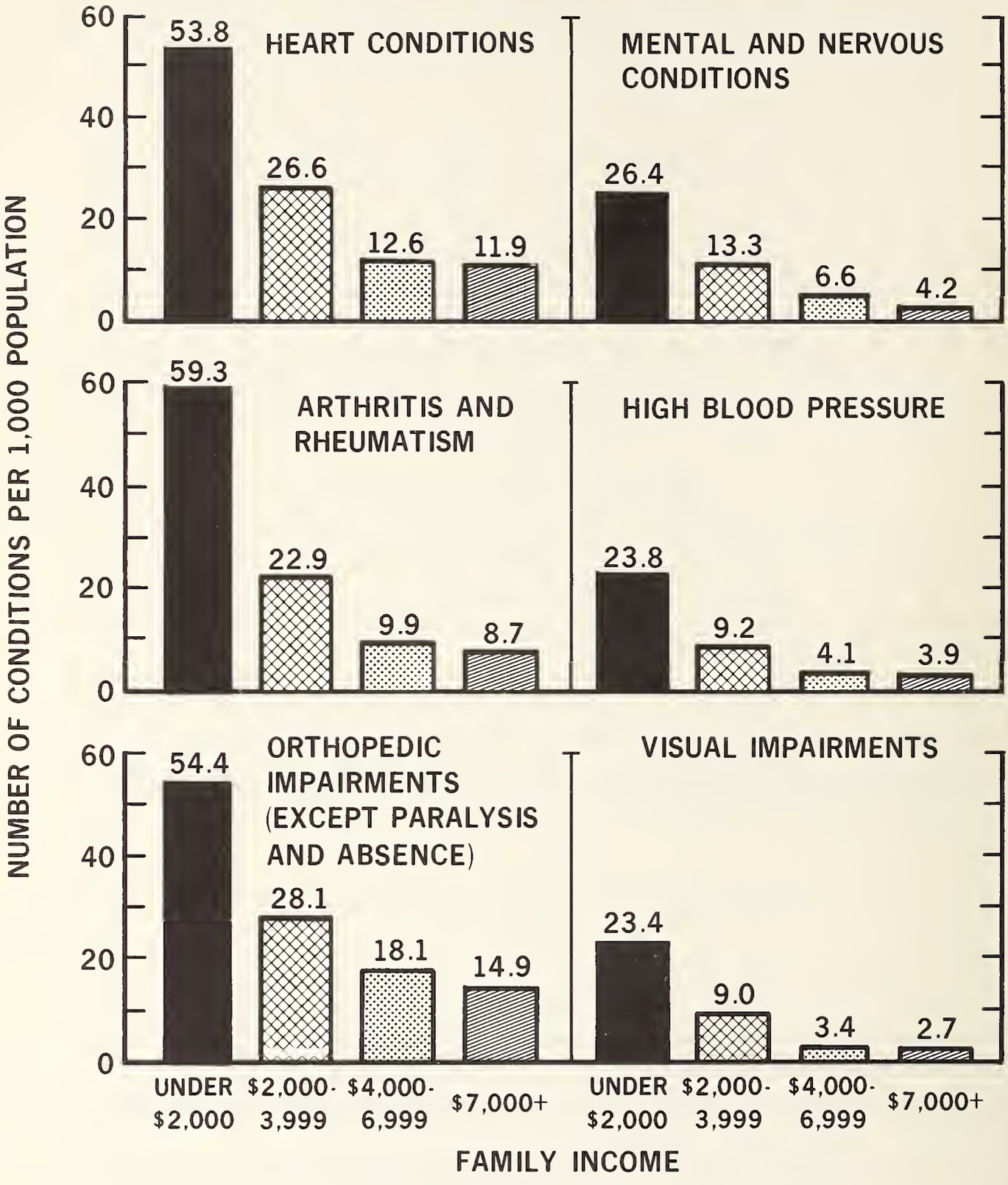
The supply of physicians has also been increasing faster than the growth in population. Between 1950 and 1966, the supply of physicians increased by 34 percent (against 29 percent growth in population), and, between 1966 and 1970, the supply of active physicians grew at twice the population rate, yielding a change in ratios of physicians to population from 141 per 100,000 in 1967 to 155 per 100,000 last year.

Both the growth in supply relative to population, and the fact that nearly every country outranking the United States on infant mortality rates has a smaller ratio of physicians and hospital beds to population, indicate that inadequate quantities of health care resources *in general* are not contributing to the health care crisis.

As in the measures of health status, the aggregate measures of health care resources hide more than they reveal.

There are, for example, large geographic variations in the ratio of physicians to population. There are 82 active physicians per 100,000 people in Mississippi, but 228 in New York. A study of 1,500 cities and towns in the upper midwest in 1965 found 1,000 without any physician, and 200 others had only one. Large metropolitan areas average 185 physicians per 100,000 people, while the average is only 76 in non-metropolitan areas. Cities, particularly the ghettos, fare far worse than the suburbs in the ratio of physicians to population. In nine out of ten Appalachian States, there are substantially fewer physicians in relation to population in the less wealthy (and generally rural) counties than there are in the wealthier counties. And

Activity–limiting conditions, by income 1964



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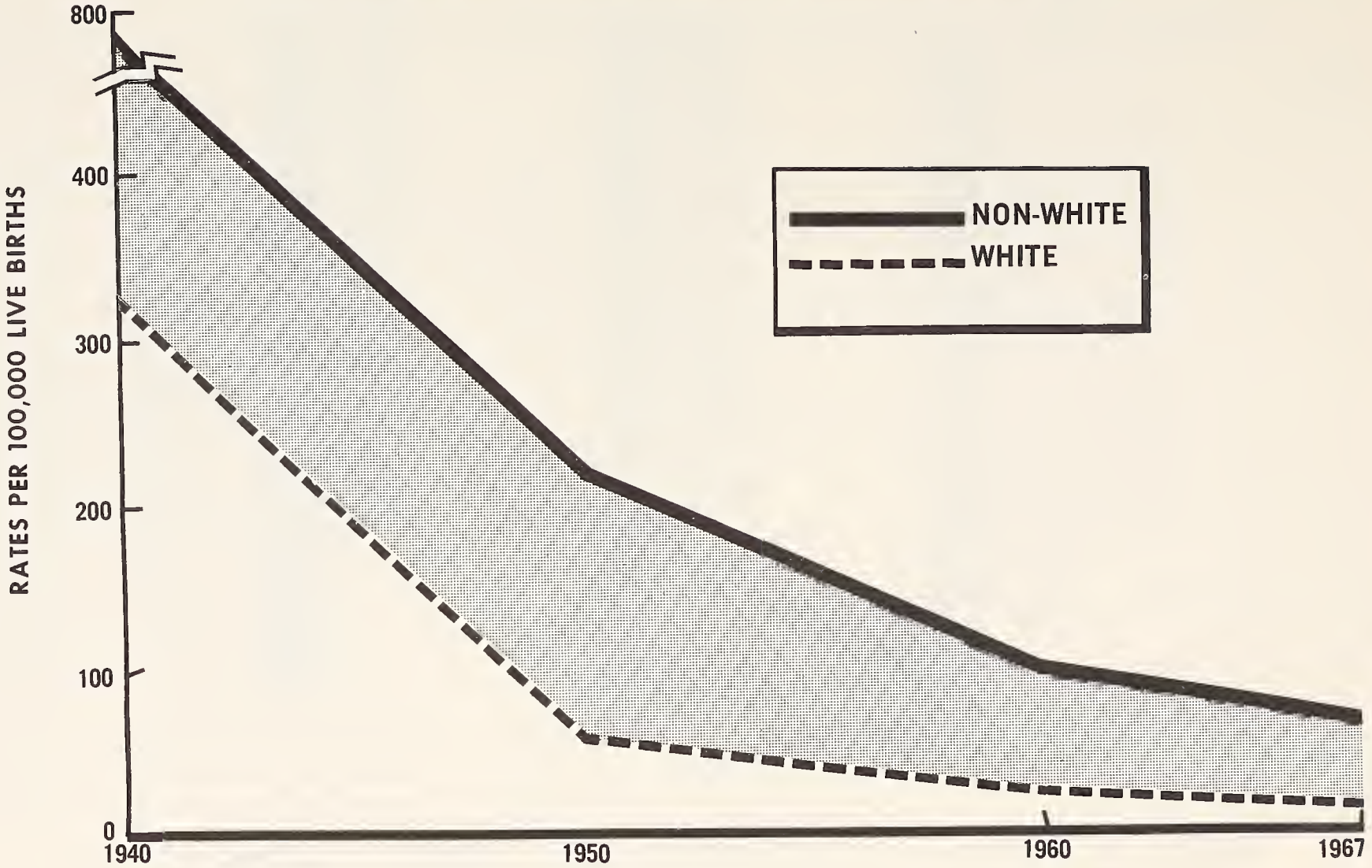
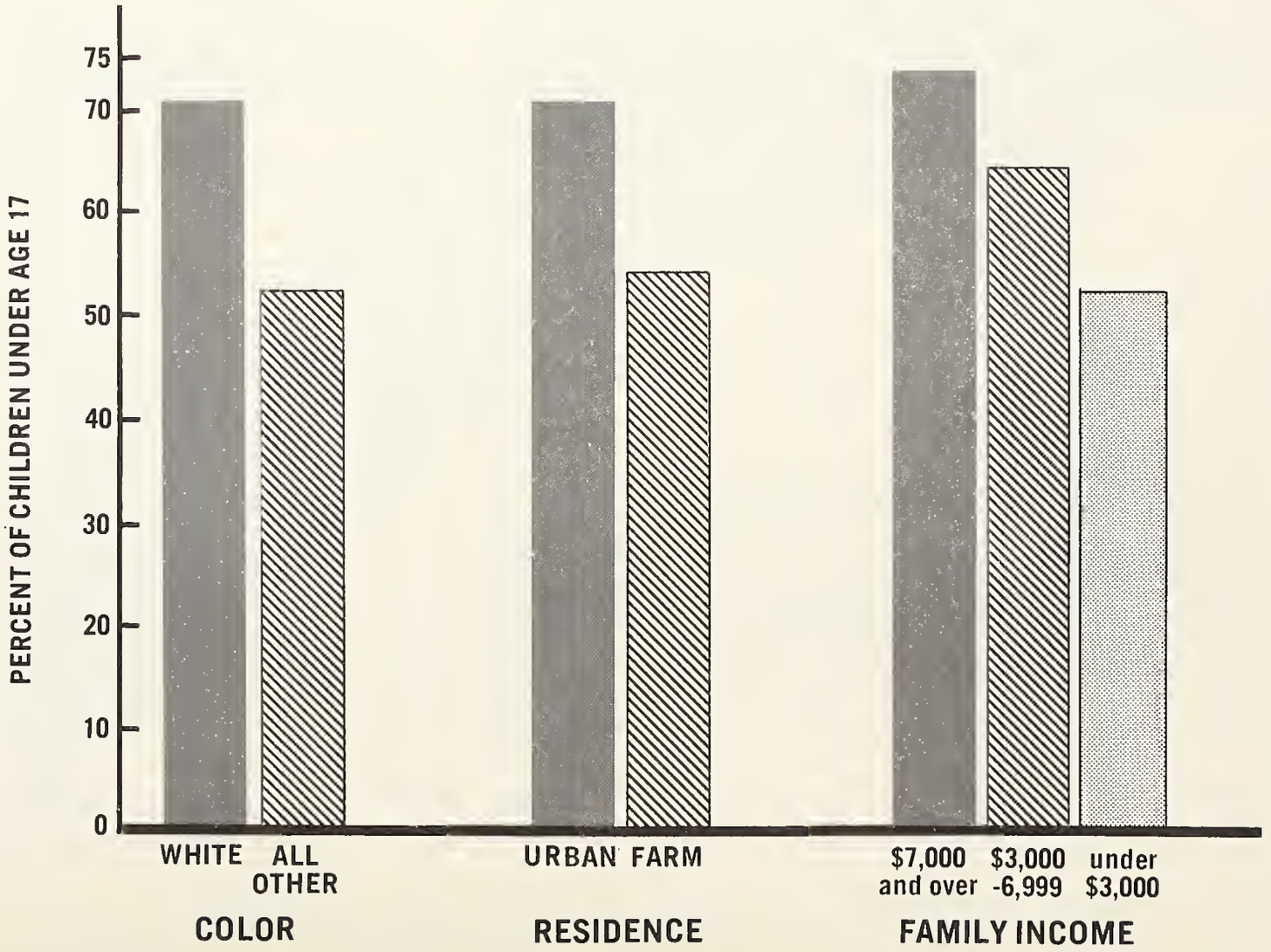
Comparison of white and non–white maternal death rates



Percentage of children seeing physicians by race, location, and income



the same disparity between wealthy and poor counties, urban and rural, occurs elsewhere in the Nation.

Another part of the health care crisis, then, results from the large disparities in the geographic location of resources. Too many people simply lack convenient access to the services of physicians; too many communities are unable to attract physicians to practice there. Without physicians, or with relatively few physicians, hospital facilities are unused or are under-used.

But geographic location is not the only factor that needs to be understood in examining our health care resources.

Primary care physicians—general practitioners, pediatricians, and internists—can handle most of the illnesses and other health care problems with which the population is afflicted. Their average fees are lower than specialists. They are generally more concerned about their patients as a whole and as members of a family than are specialists, and there is some evidence that patients who are cared for by primary care physicians tend to require less hospitalization than those who are treated by specialists. Moreover, judging from the experience of the American Medical Association's placement service in 1969, the demand is for primary care physicians. There were 2001 opportunities offered for primary care physicians, but only 864 seeking opportunities, leaving a deficit of 1,137. On the other hand, 170 opportunities were offered in surgery, but 448 seeking opportunities, leaving a surplus of 278. Pathology, obstetrics—gynecology, urology, radiology, and ophthalmology were also surplus categories.

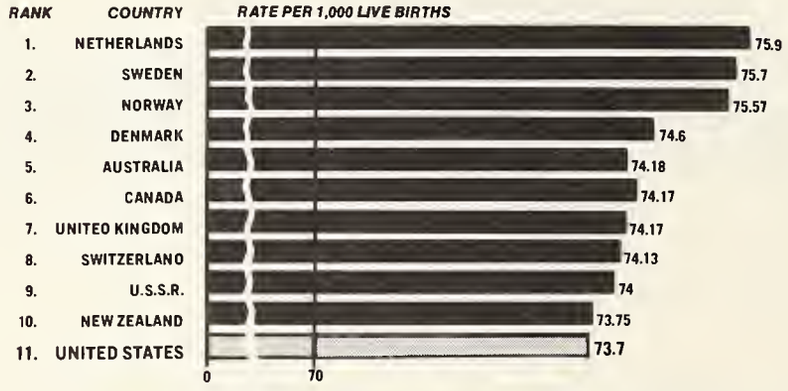
Yet the relative ratio of primary care physicians to population has been declining. In 1931, roughly 117,000 physicians out of 156,000 were primary care physicians, or 75 percent of the total. In 1967, there were roughly 115,000 primary care physicians out of 303,000 physicians, or 39 percent. From 94 primary care physicians per 100,000 people in 1931, the ratio had dropped to 73.

Two types of distributional problems, therefore, contribute to our health care problems. One is geographic, the other is type of medical practice.

Improper management of our health care resources is another important contributor to the crisis in health care. Poor utilization of these resources restricts the quantity of services available, the geographic extent to which services might reach, and the ability to control costs.

The United States ranks...18th in the world in male life expectancy at birth

The United States ranks...11th in female life expectancy at birth



The United States ranks...13th in infant mortality

The evidence that we are making poor use of our health care resources has been accumulating for some time. The Joint Council of National Pediatric Societies, for example, has stated that 75 percent of the pediatric tasks performed by a physician could be done by a properly trained child health assistant. A significant proportion of the tasks performed by obstetricians, similarly, can be performed by nurse-midwives without any loss in the quality of care. And experience with several physicians assistants programs has demonstrated that ex-medical corpsmen, or comparably trained individuals, with some additional training can assume a large number of tasks performed now by general practitioners.

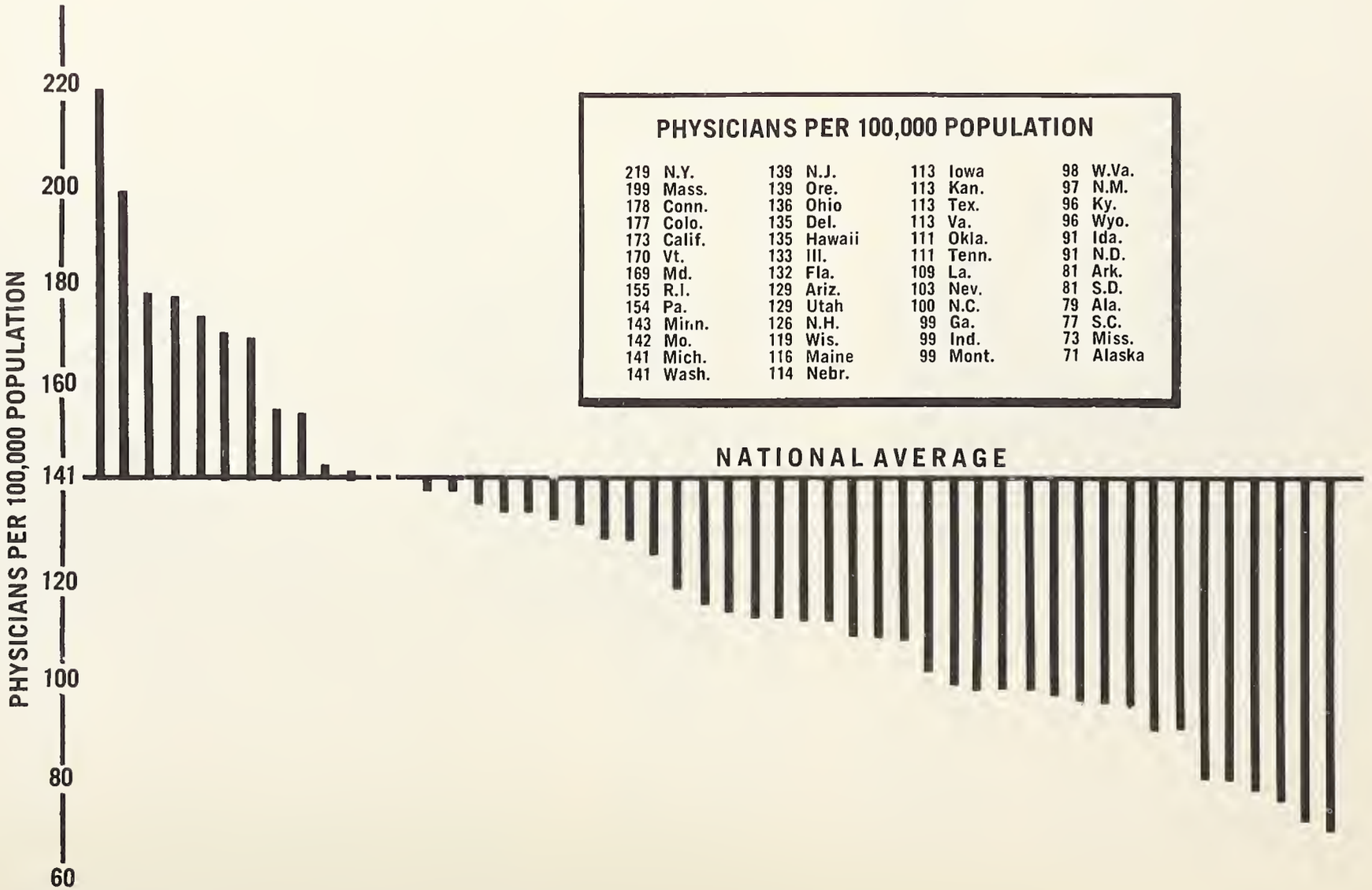
With regard to dental services, it has been amply demonstrated that one chairside assistant, efficiently used, increases a dentist's productivity by 50 percent; a second assistant adds another 25 percent; and by properly utilizing all the skills of the dental team, a dentist can more than double his productivity.

In a study of nurse manpower in 1963, it was found that the satisfaction of patients was highest when nurses devoted at least 50 percent of their time to patient care, but only 35 percent of their time, on the average, was so spent. Nurses in hospitals are still spending only 35 percent of their time in caring for patients; the remainder being utilized for administrative tasks. Nurses in physicians' offices spend even less time on the care of patients.

In every study of facilities, one finds varying percentages of patients who should be using more appropriate facilities. Patients who could be treated in the offices of physicians or could receive x-rays and other laboratory services from ambulatory care facilities are found, instead, occupying hospital beds. Other patients in hospital beds could be equally well cared for in extended care facilities or nursing homes. And there are patients in nursing homes who should be in residential facilities or boarding homes, or who would benefit from services delivered to them in their homes. Moreover, there are patients in hospitals and other facilities who stay longer than they need to for proper care. Finally, too many hospitals maintain expensive facilities that are rarely used. In 1967, 31 percent of the hospitals that had open-heart surgery facilities had not used them for a year. In addition to the cost of maintaining such facilities, they also pose a risk to the patient—the capability, when used, is likely to have deteriorated in quality.

The extent to which health care resources are poorly utilized throughout the Nation has not been measured, nor have the costs of mismanagement been calculated. Just a 10 percent improvement in efficiency would yield a saving of more than $5 billion.

Ratio of physicians to population, interstate comparisons



PHYSICIANS PER 100,000 POPULATION

219 N.Y.	139 N.J.	113 Iowa	98 W.Va.
199 Mass.	139 Ore.	113 Kan.	97 N.M.
178 Conn.	136 Ohio	113 Tex.	96 Ky.
177 Colo.	135 Del.	113 Va.	96 Wyo.
173 Calif.	135 Hawaii	111 Okla.	91 Ida.
170 Vt.	133 Ill.	111 Tenn.	91 N.D.
169 Md.	132 Fla.	109 La.	81 Ark.
155 R.I.	129 Ariz.	103 Nev.	81 S.D.
154 Pa.	129 Utah	100 N.C.	79 Ala.
143 Minn.	126 N.H.	99 Ga.	77 S.C.
142 Mo.	119 Wis.	99 Ind.	73 Miss.
141 Mich.	116 Maine	99 Mont.	71 Alaska
141 Wash.	114 Nebr.		

3. Organization of Services

In part, the mismanagement of resources is a function of the manner in which the resources are organized for the delivery of services, and therefore, the organization of services can be pinpointed as a causal factor in the health care crisis.

The system by which services are provided in this country has been described pejoratively as a "non-system" as a "cottage industry of small entrepreneurs (physicians)," and as "push-cart vending in the age of supermarkets." While increasing the size of units in the industry is not the solution to all of its problems, we must look at the scale and interrelationships among the components. Until a certain scale is reached, it is difficult if not impossible to use scarce skills on tasks for which they are best suited, or to make trade-offs between, say, hospital and home health services.

Organization of services is so intimately tied to the financing of services that further discussion of this point will be interwoven with the discussion of financing below.

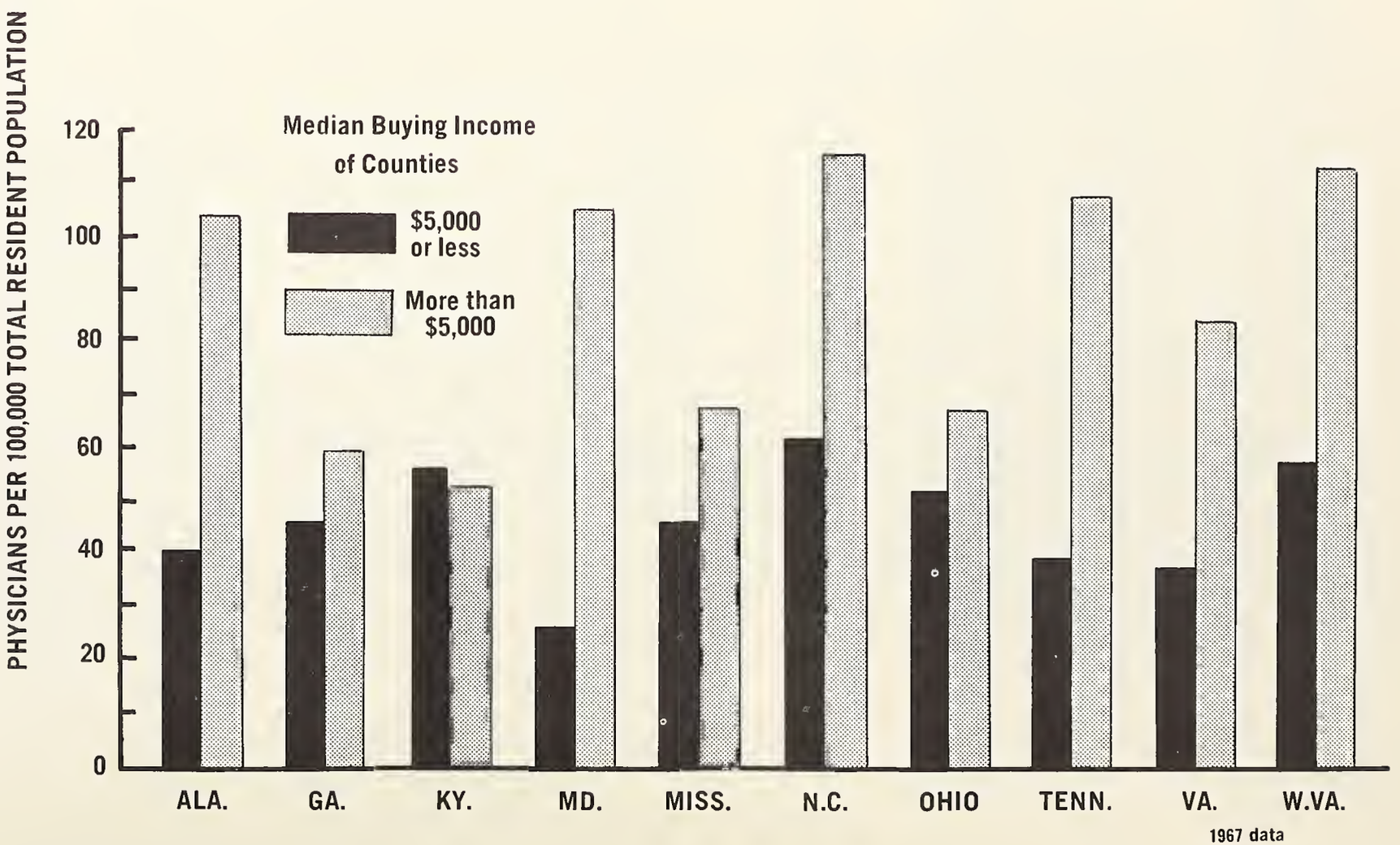
4. Financing Health Services

Expenditures on personal health care amounted to $58 billion in fiscal year 1969. The largest part—almost 63 percent—came from private sources, the remainder from public sources. About 80 percent of the population under 65 has some private health insurance, mainly for hospital and surgical coverage. About 75 percent of the working population is protected through employer-employee plans developed largely since World War II, through collective bargaining agreements. Although the workers' protection was initiated primarily to provide them with hospital and surgical coverage, protection for other types of care has been growing rapidly. Seventy percent of the population under 65 years of age is covered now for in-hospital medical visits, 65 percent for laboratory and x-ray studies, and 43 percent for visits of physicians in the patients' home or at the physicians' office.

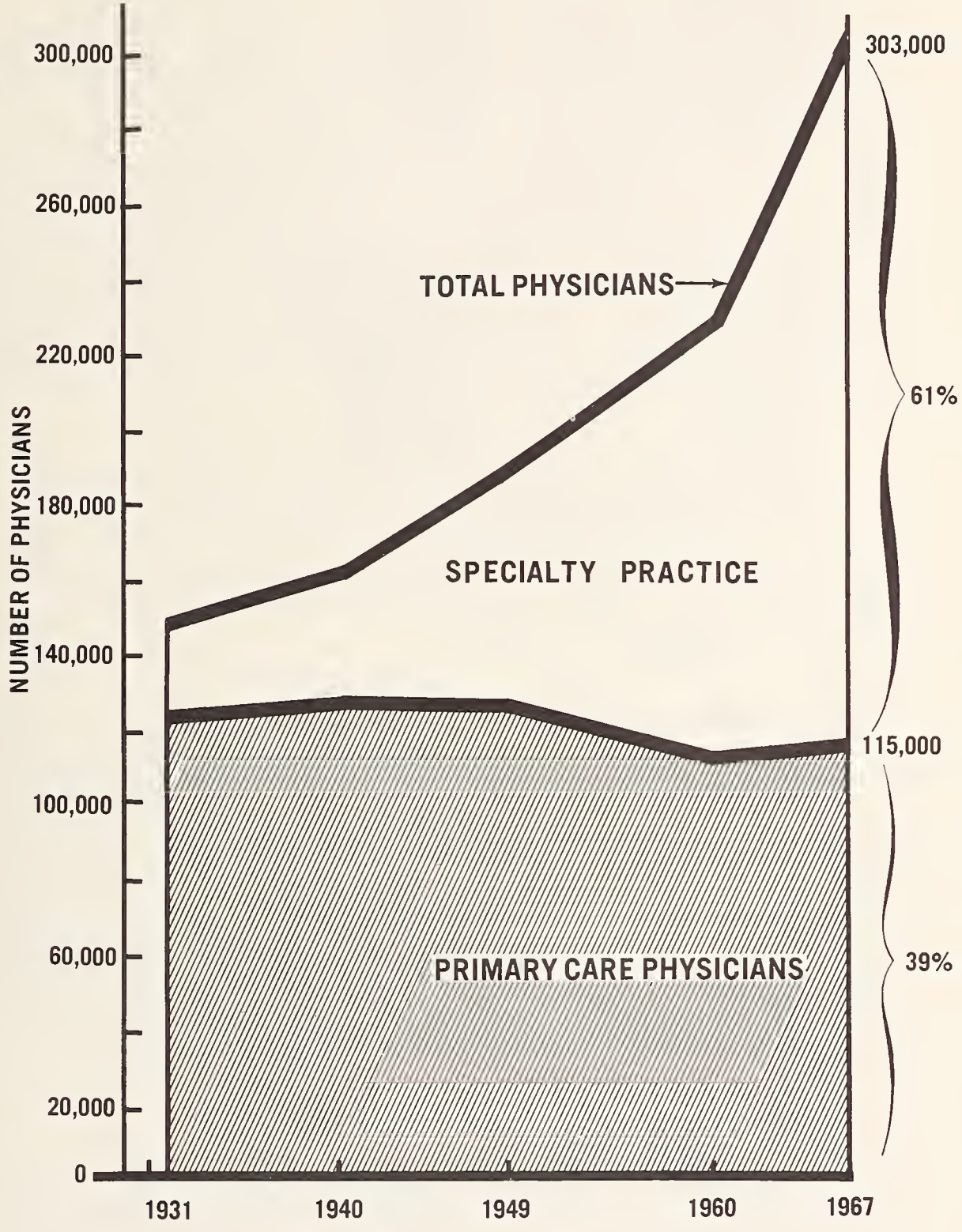
For those not covered by private insurance, Medicare and Medicaid were introduced to meet some of the needs. Medicare provides protection for more than 95 percent of the elderly, and Medicaid provides some protection for 15 million of the aged poor, the blind, the disabled, and families with children.

Over time, then, both the private and public sectors have responded to the need for protection against unplanned hospital and surgical expenses, and for other forms of care. But the growing amount and diversification of insurance coverage does not define a problem.

Ratio of physicians to population in Appalachian States, by wealth of county



Physicians in primary care and specialty practices, 1931 – 1967



There appear to be two key problems, one relating to financial barriers to the aceess of care by specific population groups, and the other to inadequate protection.

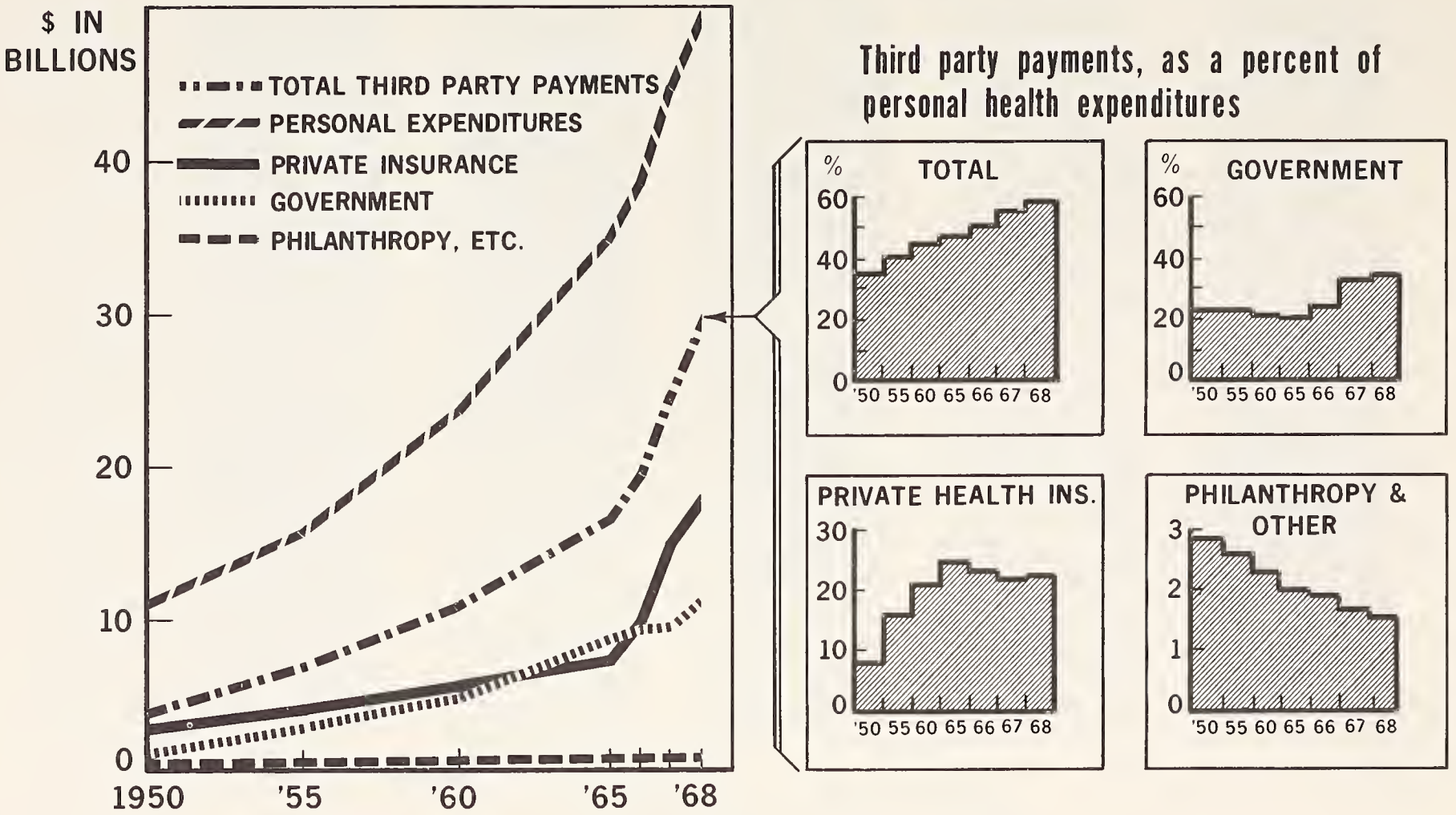
For example, while employer plans cover a majority of the population, they do not protect all of the working population, particularly the working poor. In addition, some of the plans eover the workers but not their dependents. Eligibility for Medicaid also poses financial barriers. Eligibility varies widely among the States, many of which exclude the working poor and adults in families headed by a male. Under these circumstances, half the families with incomes under $5,000 a year and two-thirds of the families with incomes under $3,000 have no insuranee. Others exeluded from protection are: children and mothers in low-and middle-income families; the unemployed and their dependents; lower income self-employed people; employed people (mainly the working poor) whose employers offer no health plans; and migrant and seasonal workers.

The inadequacy of benefits is the second key problem. While more private health insurance provides good protection against the costs of inpatient hospital care and surgery, outpatient care and preventive services are often excluded. It also exeludes or limits preventive services and maternity eare, and most families are inadequately protected against catastrophic incidents.

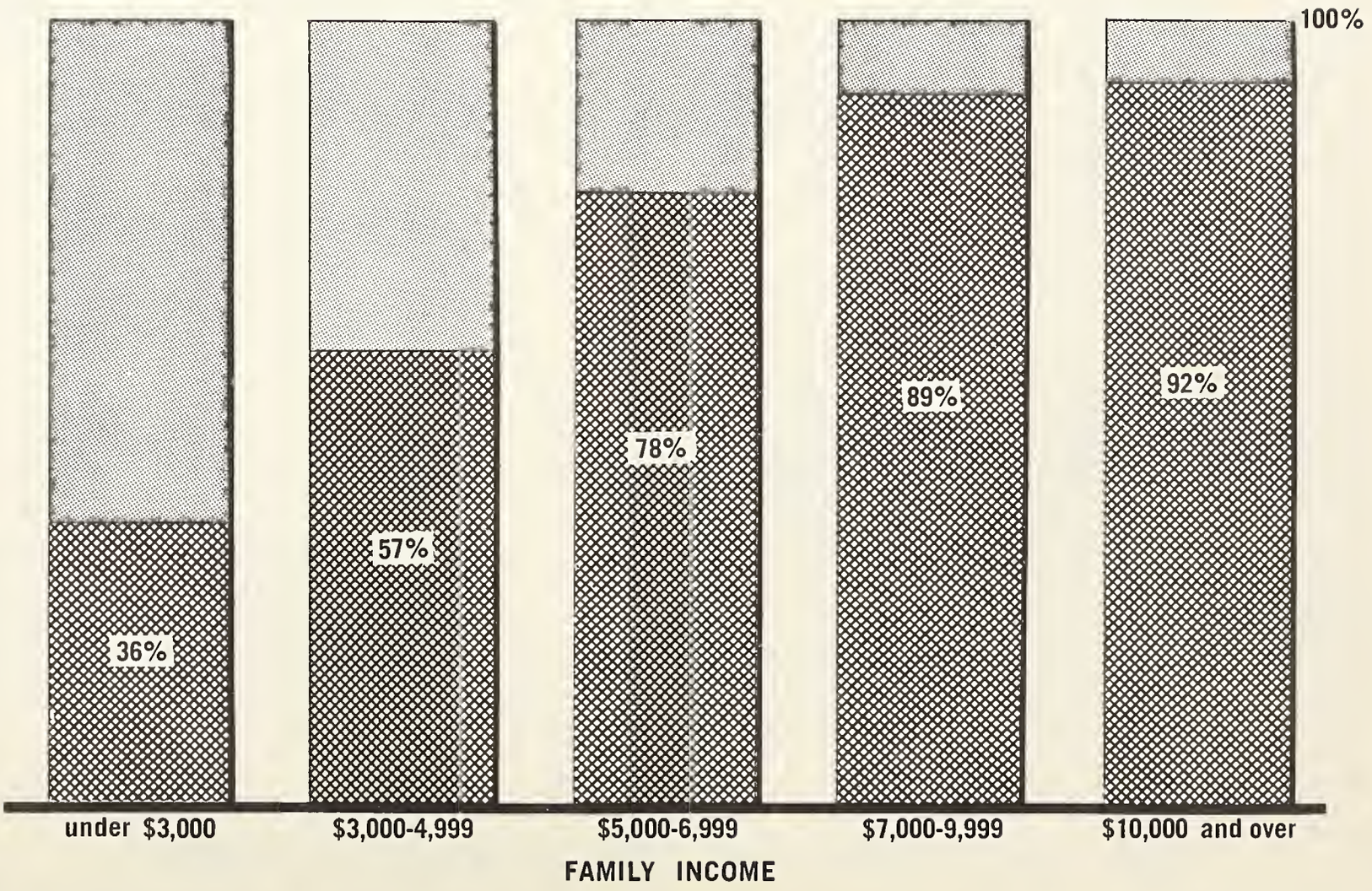
For the most part, private and public financing of health care has reinforced the existing system of delivering care, including the defects in the system. For Medicare and Medieaid to be passed by the Congress, for example, it had to fit into the existing means of delivering eare. Apart from the organizations that have provided care on a prepaid basis (which will be diseussed under "health maintenanee organizations"), the usual mode of delivery has helped produce a financing response that has lacked cost control measures or restrainod the use of high cost facilities and procedures. Indeed, it has encouraged the inappropriate use of high cost facilities and services when other less expensive alternatives were available. And finally, both the manner of organizing services and their financing have favored care and rehabilitation over prevention.

Another part of the health care crisis, in sum, stems from intolerable exelusions of large numbers in the population from financial access to eare, inadequate benefits, and unneeessarily high costs resulting from a mutually reinforeing financing and delivery system.

Health care expenditures: Third party payments, 1950 – 1968



Proportion of persons under age 65 with hospital insurance in relation to family income



5. Medical Costs

Medical costs have been alluded to in several of the preceding sections, but since the inflation in medical costs is undeniably one of the aspects of the medical care crisis, the subject deserves special attention.

In fiscal year 1970, the Nation spent $67 billion on health, nearly three-fifths again as much as had been spent only four years earlier. While undoubtedly there were improvements in the quality of care for at least some of the population, more than 75 percent of the increase in expenditures for hospital care and nearly 70 percent of the increase for physician services, were the consequences of inflation.

In the decade of the 1960's, medical care prices rose far more rapidly than prices in general. Hospital charges rose four times as fast as other items in the Consumer Price Index, and physicians' fees at twice the rate. These two items—hospital care and physicians' services—are the major contributors to the inflation of medical costs.

Some of the causes for inflation in medical costs have already been mentioned: poor utilization of scarce resources, incentives for the use of the highest cost facilities, and lack of cost control measures. But there are other causes, some of which are exceedingly complex and are not fully understood. There are, for example, legal barriers in some States to the formation of group practices, and other legal barriers prohibiting physicians and dentists from delegating responsibilities of certain kinds or to certain numbers of assistants. The "market" for care is one in which a great deal of information is veiled from the consumer—i.e., the consumer is unable to pass judgment on the quality of services received, and he is frequently in circumstances (acutely ill) where he cannot bargain over the services. It is a "market" furthermore, where increasingly one party sets prices for services, a second receives them, and a third pays for them, so that no one is concerned about rising costs. The health industry has consistently underpaid its employees (excepting physicians) who, in effect, subsidized a portion of the patients' care. And, finally, productivity in this industry lags behind the productivity of the goods-producing sector, thereby creating an inflationary gap. Insofar as physicians' fees alone are considered, the physicians' demand for income has probably risen faster than any other occupation's demand. A recent study found that, on the average, a physician's rate of return on his educational investment (which includes both his outlays on education and the income he has foregone as a student) is currently about 24 percent. In other words, in four years, his income will match all of his educational costs.

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6. Medical and Dental Education

Still another aspect of the health care crisis has been the financial crisis of a large number of the Nation's medical and dental schools. Many schools have been dipping into their endowment funds; others have been limping along, on the verge of bankruptcy year after year. At the same time, they have been urged to expand their enrollments and to take on new roles in the training of manpower and in providing community services.

The components of medical education—research, services, and teaching—are so interwoven that it has been virtually impossible to determine the causes of the financial difficulties. Several studies are currently in progress to sort out this problem. It appears that at least part of the explanation will be found among the following reasons.

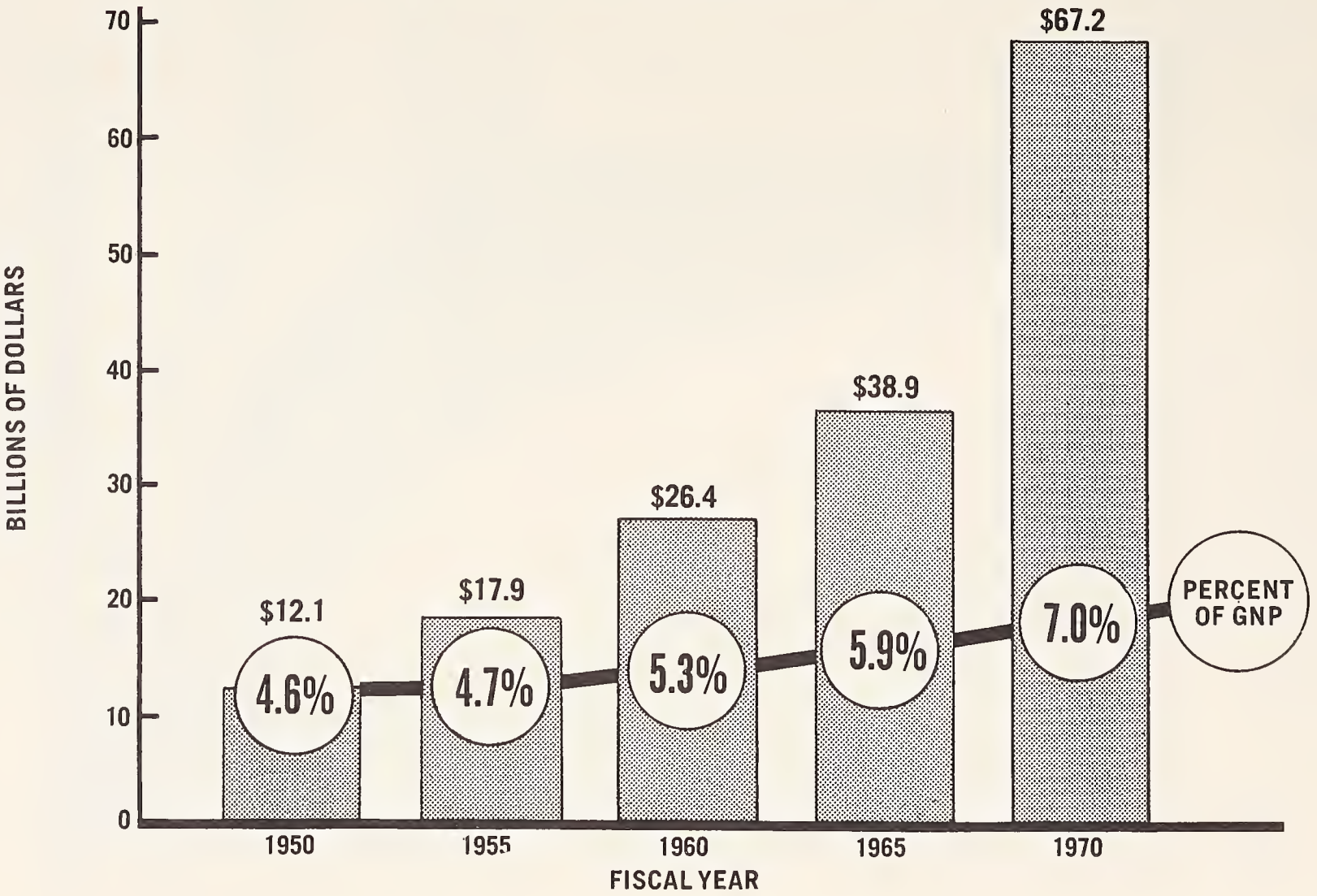
Services offered in teaching hospitals differ markedly from those in community hospitals. They are more "labor-intensive;" they have more and better laboratory backup capabilities; and they provide care for the most difficult medical cases. Accordingly, costs are higher than in community hospitals, and reimbursements do not compensate fully for the additional costs.

There has been little incentive for efficiency in the educational process. Most medical schools have their own basic science departments—for the pre-clinical years of training—duplicating in large measure the basic science departments of universities. While there have been efforts in recent years to prune and reform curriculums, reducing the length of a medical education in the process, far more needs to be done in this respect.

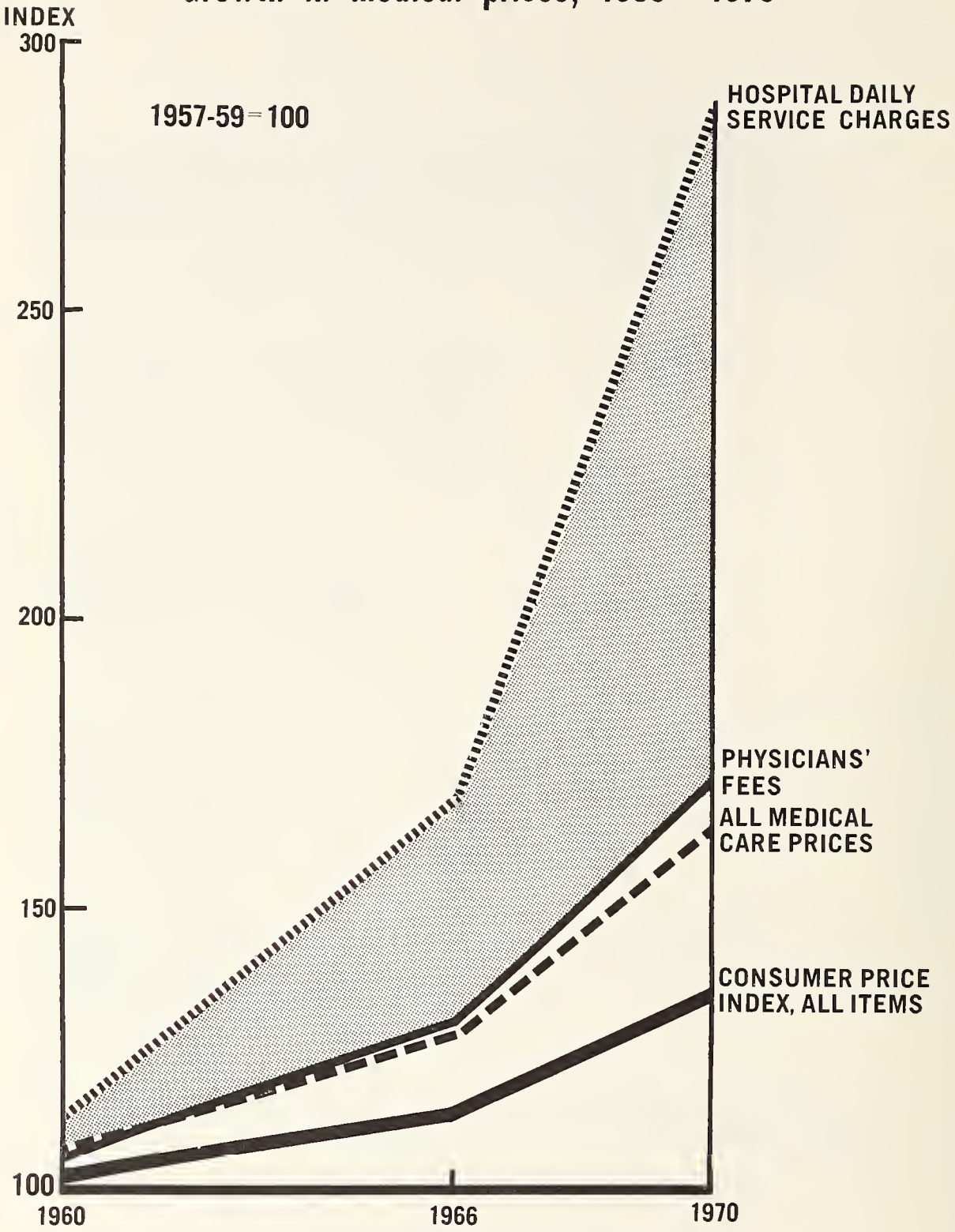
Medical schools have sought their own teaching hospitals, even though there may have been a surplus of hospital beds in the area, and when they could have converted a community hospital into a teaching hospital, thereby upgrading its quality of care.

There are undoubtedly many other reasons, including inadequate tuition charges, the decline in voluntary donations, and the lack of productivity increases commensurate with those in the goods industry. The inescapable fact, in any case, is that the professional schools are in trouble.

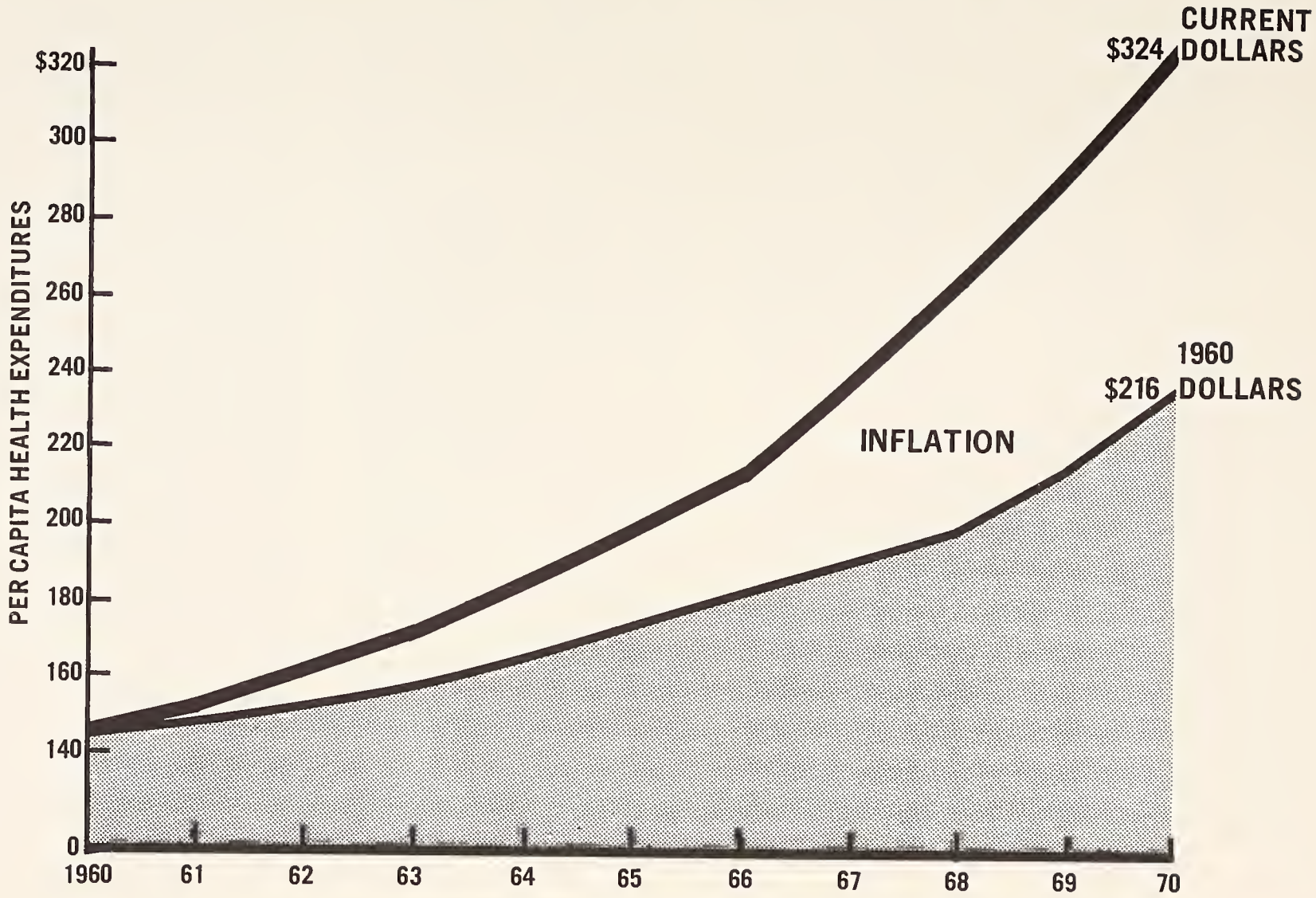
Growth in health expenditures, 1950 –1970



Growth in medical prices, 1960 –1970



Inflation's share of health expenditures in the 1960's



II

SOLUTIONS TO THE PROBLEMS

The solutions proposed by the Administration form an interlocking strategy. The entire "health care crisis" is addressed, from prevention of illness and injury to the financing of health services, from incentives to encourage a better distribution of health services to assistance and incentives for our professional schools.

Since the President's health message was delivered on February 18, and the Secretary of the Department of Health, Education, and Welfare testified on February 22 before the Senate Health Subcommittee on the Health Care Crisis in America, two key criticisms of the Administration's strategy have emerged. The first raises the question of "generosity"—has the Administration offered sufficient support? The second asks whether private health insurance should not be replaced with public insurance?

These are difficult issues. The extent to which anyone or any institution is generous depends upon the other things it wants to do or has to do. As pointed out in the Foreword, the claims for medical care cannot be treated in isolation; there are other, equally important claims, some of which will have a major, indirect impact on health. It is easy to say, "I would do more than you for so-and-so," if one does not have to add, "And to do more, I'll take from there." To do more in medical care is to do less either in other public sector programs or in the private sector (i.e., raise taxes). The central issue, therefore, is really whether, given all the other competing claims, the Administration's strategy is reasonable at this time. In future years, other claims may not be as urgent, and resources may thus be freed for additional health efforts.

The second issue—reliance upon the private insurance industry—in part poses the dilemma of the half-filled bottle. Some will look at it and say it is half-empty, rather than half-filled. The Administration looks at the accomplishments of the health insurance industry in the absence of guidance or regulation over the past two or three decades—its increasing coverage and diversification of benefits—and concludes that, on balance, the bottle is half-filled. It believes that no insurmountable problems have arisen, and that, with reforms, the bottle can be filled.

It is not an issue, to continue the metaphor, of "new wine in old bottles." That, too, is an easy assertion. Rather, it is a matter of preserving and strengthening institutions in the private sector, in the interest of maintaining pluralistic sources of ideas and power. For in doing so, the

Nation maintains the checks and balances that have been the strength of its political economy. To abolish the health insurance industry, and to replace it with a single Governmental system, is to set in motion a series of events with a predictable outcome. At some point, and the point is not far off, the economies of scale are transformed into diseconomies. The single, enormous organization begins to break down under the weight of administrative complexities—coordination among the parts becomes inordinately difficult, layers of bureaucratic hierarchies frustrate communications, and attention to quality becomes distracted. These are common and universal experiences with large organizations. There is no point in comparing, as has been done, a single governmental insurance system with the present Social Security Administration because the SSA collects and dispenses money on a formula basis in the absence of any discretionary freedom. But a single governmental system would be involved in a vast number of judgmental issues affecting all parts of the Nation. Moreover, a monolithic governmental system would (in the extant proposal for such a system) force economization through the imposition of a budget ceiling—only so much, and not any more, for the system as a whole. This assumes, however, a planning and budgeting capability that, in reality, would take years to muster. It would also, obviously, invest enormous responsibility in the central system. Furthermore, one should not assume that costs can be transferred from the heterogenous system we have to a single payroll system without some slippage. The experience of the United Kingdom indicates a marked amount of slippage—people buy services outside of the system, so that the true costs are equal to the system expenditures plus outside purchases.

Finally, the Administration has seen no evidence that justifies the conclusion that the private health insurance industry has been so derelict in performance, and so unresponsive to private needs, that the only solution is to abolish the industry. Instruments of reform, rather than those of warfare, appear to be more appropriate to the occasion.

And now we turn to the Administration's proposals for a comprehensive health strategy.

1. Prevention

Preventing premature deaths, illness, and injury is a major part of the Administration's strategy. Not only does prevention alleviate human suffering, and perhaps contribute to "a positive sense of physical and mental well-being," but expenditures on prevention can be traded off economically with expenditures on treatment and rehabilitation. A major proportion of the prevention proposals strikes at the inequities experienced by the poor. Other proposals are targeted upon major problems afflicting large numbers in our population, irrespective of income. Four criteria guided selection from

among all the alternatives. First, the problem was important and widespread. Second, effective means for dealing with the problem were available. Third, new opportunities had emerged (as in cancer research) which would be well worth exploiting. And fourth, the likely benefits justified the expected costs.

Welfare Reforms. The President's proposed welfare reforms, while serving other purposes as well, are an essential element in the health strategy. Firmly established relationships between income and health status point to an elevation in health status through income maintenance. In addition, the negative aspects of the current welfare programs, which encourage the breakup of families and the rearing of children in the absence of their fathers, are undoubtedly contributing to poor mental health; their elimination should therefore contribute to improvements in mental as well as physical health.

Nutrition. Inadequate nutrition has been linked with a number of physical and mental health problems, from iron deficiency anemia to diminution of intellectual performance. In the past 2 years, the Administration has increased the allotment of food stamps, and has decreased their price. Nearly all of the 3,000 counties in the Nation now have a food stamp or commodity distribution program; they serve more than 12 million people. Federal expenditures on food stamps nearly tripled between fiscal years 1970 and 1971—from $577 million to $1.7 billion. The President has requested $1.9 billion in his FY '72 budget. Nutrition programs for children, including the school lunch program, nearly doubled between fiscal years 1970 and 1971, reaching $951 million in FY 1971, and an additional $40 million has been requested for FY '72. The Administration has also liberalized the regulations of the school lunch program to reach more of the needy children.

In order to enable people to make their own decisions, the Administration seeks to substitute income for services wherever feasible. Accordingly, the Administration is considering at this time substituting additional income for food stamps in its welfare reform proposals.

Poor nutrition is not a problem solely of the disadvantaged. The affluent frequently consume more calories than they can reasonably expend in work or play; they are consuming more low-nutrition snack food than ever before as well as a number of foods with "empty calories." One indicator of the deterioration in the American diet is the 65 percent increase in the consumption of sweets between 1958 and 1968. The Administration proposes bringing together the forces of the Food and Drug Administration, the Federal Trade Commission, the National Academy of Sciences—National Research Council, the Advertising Council of America, and the food industry to develop nutritional guidelines, nutritional labeling, and information for

consumers on proper eating, as well as enforcing regulations to ensure that the nutritional value of food products is not misleadingly stated in advertising.

Family Planning. As a health measure, family planning not only allows women to avoid the birth of unwanted children (a mental health factor, among other things), but can also prevent illness and death of mothers and children through the proper spacing of births or the avoidance of births under high risk circumstances. In 1963-65, the infant death rate of the fifth child born to non-white women under the age of 20 was 127.6 per 1,000 births, in contrast with the average infant death rate for non-white women under the age of 19 of 49.5 per 1,000 live births. For fiscal year 1972, the Administration has requested $173 million for services and research on population and family planning—an increase of $64 million over the preceding year. With the family planning funds, services will be provided for half the women who want but cannot afford them. This will constitute substantial progress toward the President's goal set in July 1969—a five-year target date for universal access to family planning services.

Occupational Health and Safety. On-the-job accidents resulted in 14,500 deaths and more than 2,000,000 disabling injuries last year. The Administration's new Occupational Health and Safety Act (1970) enables the Secretary of Labor to implement existing safety standards and to establish other Federal standards within the next 2 years to promote occupational health and safety. The law also authorizes emergency temporary standards in the event of grave dangers from toxic agents or new hazards, and establishes strict enforcement and inspection measures. The Department of Health, Education, and Welfare is creating a new National Institute for Occupational Health and Safety to conduct research and experiments that will lead to improved and new standards.

Automobile Accidents and Alcoholism. In 1969, 56,000 people were killed and 4,700,000 were injured in motor vehicle accidents. Half of the deaths involved drivers or pedestrians under the influence of alcohol. Drinking drivers and pedestrians were involved in at least 800,000 automobile accidents. The Administration has initiated a comprehensive program to reduce alcohol-related deaths and injuries on our highways. The program constitutes an integrated package of counter-measures designed to identify, control, and provide surveillance of the drunk driver. Its activities will impinge on law enforcement, traffic courts, special counseling and assistance for drivers, and public education. The Administration has requested more than a fourfold increase in the appropriation for this program—from its fiscal 1971 level of $8 million to $35 million in fiscal 1972.

Pollution Control. There is increasing evidence that persistently high levels of air pollution increase the incidence of respiratory diseases, some skin conditions, and some of the chronic diseases. Steps that are now being taken to reduce the pollution from automobiles drastically below current levels by 1976, to develop alternatives to the internal combustion engine, to reduce sulfur oxides emissions from fossil fuels, and to find new alternatives to fossil fuels will have long-term payoffs in prevention. Strong standards are placing the cost of pollution control on the industries that produce the pollution, and on the consumer of their products, rather than, as now, on society as a whole. Last year, public utilities and other industries spent nearly $500 million to control sulfur oxides emissions.

Health Research. The Administration's FY '72 budget has requested $1.8 billion for health research, somewhat more than $100 million for the preceding year, and $266 million above FY 1970. These funds, for the most part, will continue research on the prevention and control of the major diseases and impairments that afflict our citizens. In addition, the Administration has proposed to launch a major program to conquer cancer, based on enthusiastic reports from the scientific community that an impressive range of opportunities has opened up in fields such as genetics, molecular biology, virology, and cell physiology which show exceptional promise of fulfilling the objective. $100 million additional has been requested for this purpose, bringing the budget to more than $330 million for cancer research.

The Administration has also requested a sixfold increase in the budget for an intensified program of basic and clinical research on sickle-cell anemia. This disease, which takes its name from the shape of cells found in persons with the disease, results in general lassitude and periods of crisis (attacks) characterized by severe bone pain and organ dysfunction. It increases the susceptibility of a person to infectious diseases. Children with sickle-cell anemia tend to do poorly in school, and adults have major employment difficulties resulting from fatigue and absences. The disease is hereditary and is found almost exclusively in persons of African descent. It is estimated that about 10 percent of the black population in America carry the sickle-cell genetic trait, and about one in 500 black Americans actually has the disease.

Prevention of Communicable Diseases. Among the venereal diseases, gonorrhea has been increasing at the rate of 10 to 15 percent a year over the past 4 years, and cases of syphilis also are on the upswing. It is estimated that there were 2.5 million cases of gonorrhea and 100,000 cases of syphilis last year.

There has also been a decline in immunizations against certain communicable diseases. The major problems are in urban poverty areas, where the proportion of children between the ages of 1 and 4 who have received measles vaccinations declined from 46 percent in 1969 to 41

percent in 1970. Vaccinations against diphtheria, pertussis, and tetanus declined in the same period from 27 percent to 23 percent, and polio vaccinations have dropped from 55 percent to 50 percent. Overall, 10 to 15 percent fewer of the young population in urban poverty areas received vaccinations against these diseases in 1970 than in 1969. The proportion of the population now immunized is so low that new outbreaks of measles, diphtheria, and polio could occur. The Administration intends to take corrective action. Because of the 50 percent drop in the price of rubella vaccine, and slippages in the purchase of this vaccine by State Departments of Health, $6 million can be re-allocated for vaccinations against the communicable diseases enumerated above.

Furthermore, the Administration plans to step up efforts considerably to enable communities to regain control over communicable diseases. An additional $10 million would be allocated for these purposes through the Partnership for Health program.

Lead Paint Poisoning. Paint with lead in it poisons about 400,000 children (predominantly poor) annually. It is estimated that 16,000 of these children require treatment, 3,200 incur moderate to severe brain damage, and 800 are so severely brain damaged that they require care for the rest of their lives. The Administration plans to make a significant start on programs to overcome this problem. The FY 1972 budget will allocate $2 million for this objective.

Product Safety. The Administration will expand its efforts to protect consumers against hazardous foods, drugs, and other products potentially dangerous to health. Inspection of domestic and imported foodstuffs, along with research on foods containing mycotoxins (fungal or bacterial poisons) and poisonous metals, will be stepped up. A program to review chemicals in foods will be established, and a cooperative program with industry will be initiated to assure the quality of foods. Efforts to improve the safety and efficacy of drugs will also be increased. For these and related purposes, $9.5 million has been incorporated in the FY 1972 budget, an increase of 11.5 percent over the preceding year.

Indian Health. Preventive health programs are the major thrust of the direct Federal responsibility for Indian health. As the result of previous efforts, infant death rates have dropped more than half in the last 15 years, and tuberculosis deaths have declined more than threefold. Current emphases are on sanitary conditions, physical rehabilitation, improved nutrition, and lowering rates of alcoholism and suicide. The Administration has proposed increasing the funding of Indian health programs by $18 million, rising from $141 million in FY 1971 to $159 million in FY 72, with a special emphasis on building sanitary facilities in homes without them.

Personal Responsibility for Health. Impressive gains in the prevention of illness and death could be made if our citizens were better informed about the actions they might take—and were encouraged to take—to improve their health. Over-indulgence in foods and alcoholic beverages, cigarette smoking, excessive use of drugs and nostrums, inadequate exercise, and insufficient attention to indicative physiological changes, all contribute to unnecessary and avoidable illnesses. The Administration has stimulated the formation of a National Health Education Foundation, a private, nonprofit organization that will receive no Federal funds. It will be sponsored by business, labor, the health professions, the insurance industry, and health and welfare organizations. The Foundation will undertake a comprehensive health education program to promote preventive actions that citizens can undertake on their own behalf.

Financial Incentives for Preventive Health Care. As part of its insurance proposals, which are discussed later, the Administration has recommended benefit packages that include incentives for preventive health services, ranging from immunizations to screening examinations.

These, then, constitute the alternatives the Administration has selected to prevent illnesses and injuries. It has rejected a number of alternatives on the basis of the criteria mentioned at the outset of this section. As time and circumstances change, and as we increase our knowledge about how to undertake other cost-effective preventive measures, the list will undoubtedly be lengthened.

2. Innovation and Reform in Health Care: Health Maintenance Organizations

Another key part of the Administration's health strategy is the Health Maintenance Organization (HMOs). HMOs simultaneously attack many of the problems comprising the health care crisis. They emphasize prevention and early care; they provide incentives for holding down costs and for increasing the productivity of resources; they offer opportunities for improving the quality of care; they provide a means for improving the geographic distribution of care; and, by mobilizing private capital and managerial talent, they reduce the need for Federal funds and direct controls. They also contain shortcomings, which will be described later on, that must be guarded against.

HMOs are organized *systems* of health care, providing comprehensive services for enrolled members, for a fixed, prepaid annual fee. No matter how each HMO may choose to organize itself (and there are various models), from the consumer's viewpoint they all provide a mix of outpatient and hospital services through a single organization and a single payment mechanism.*

*The Kaiser Permanente health care organization is an example of an HMO.

Because HMO revenues are fixed, their incentives are to keep patients well, for they benefit from patient well-days, not sickness. Their entire cost structure is geared to preventing illness and, failing that, to promoting prompt recovery through the least costly services consistent with maintaining quality. In contrast with prevailing cost-plus insurance plans, the HMO's financial incentives encourage the least utilization of high cost forms of care, and also tend to limit unnecessary procedures.

HMOs provide settings for innovative teaching programs (using the entire team of health professionals and supporting personnel), as well as for continuing education programs for practitioners. They also provide a setting in which new technologies and management tools can be most effectively employed, in which the delegation of tasks from physicians to supporting personnel is encouraged, and in which close and constant professional review of performance will provide quality controls among colleagues.

HMOs are not wholly new, and more than 7 million Americans now receive comprehensive health care from HMO-type organizations, and about 20 percent of the population lives within their service areas. The evidence that has been derived from the existing organizations provided the basis for the Administration's decision to encourage their rapid and widespread development.

In contrast with more traditional and alternative modes of care, HMOs show lower utilization rates for the most expensive types of care (measured by hospital days in particular); they tend to reduce the consumer's total health-care outlay; and—the ultimate test—they appear to deliver services of high quality. Available research studies show that HMO members are more likely than other population groups to receive such preventive measures as general checkups and prenatal care, and to seek care within one day of the onset of symptoms of illness or injuries.

These studies show that hospitalization is significantly reduced in HMOs, and that this reduction is accomplished by prevention, by performing more procedures in the doctor's office (minor surgery, for example), and by reducing unnecessary procedures. They show that alternative modes of service overhospitalize for common respiratory conditions and for such minor surgical conditions as benign neoplasms, tonsillectomies, and accidental injuries. Reduced utilization within the HMO framework is selective—it reflects rigorous professional controls and is not sought as an end in itself. Typical findings are shown in the accompanying table.

COMPARATIVE PERFORMANCE OF HMOs ON HOSPITAL USE

	HMO	*Other*
Number of hospital days per 1,000 persons per year	744	955
Number of hospital admissions per 1,000 persons per year	70	88
Hospitalized surgical cases per 1,000 persons per year	49	69
Tonsillectomies per 1,000 persons per year	47	94

(Data standardized for age, sex, income, residence, and, excepting tonsillectomy rates, for out-of-plan services.)

SOURCES: Denson et al., *American Journal of Public Health* 50 (November 1960). Denson et al., *Hospital Monograph Series* 3 (American Hospital Association, 1958).

A variety of research studies and investigations have contrasted the cost of health care under HMOs with that of traditional practice. They all tend to the same conclusion: that HMOs lower the total health-care costs of families and individuals, and that their premiums cover a greater percentage of total costs.

This conclusion is supported by data from the Social Security Administration on Medicare experience: they show that some HMOs are saving as much as 15 percent on their elderly enrollees, in comparison with costs under traditional modes of practice. Another significant measure of at least potential cost-savings within the HMO framework is that of reduced hospital utilization rates. Based on 1968 figures, if the hospital stays of all Medicare beneficiaries who were admitted to the hospital could have been reduced by just one day on the average, the costs would have been reduced by $314.6 million. And the number of hospital beds required would have been reduced by 15,000 for the year. At an annual operating expense of $25,000, the savings in one year on the beds would have been $375 million. Current Medicare data as well as the results of one particularly careful study of family health care expenses are shown on the next table.

COMPARATIVE PERFORMANCE OF HMOs ON COST

Annual Health Costs per Family

	HMO	*Insurance Plan One*	*Insurance Plan Two*
Premium costs	$122	$115	$110
Out-of-pocket costs	102	137	149
Total costs	224	252	259

(Data standardized for age, sex, location, family size, and occupational class.)

SOURCE: "Family Medical Care under Three Types of Health Insurance," Columbia University School of Public Health, 1962.

Average Medicare Benefit Payments per Person for HMO and non-HMO Beneficiaries in Two Regions, 1968

	Medicare Payments
Region One	
non-HMO persons	$388
HMO persons	330
HMO as a percent of non-HMO	85% (15% savings)
Region Two	
non-HMO persons	$399
HMO persons	379
HMO as a percent of non-HMO	93% (7% savings)

(Data standardized by age and residence.)

SOURCE: Social Security Administration, Office of Research and Statistics.

The best, and perhaps the only test of any health care system is the health of its patients. Less hospitalization, less surgery, and lower costs do not in themselves equal desirable care. Costs and services can be low for undesirable reasons.

Results for three indicators—premature birth rates, infant mortality, and elderly mortality—suggest that HMOs can improve chances for life itself. Such results, shown below, confirm the 1967 findings of the National Advisory Commission on Health Manpower that HMOs deliver high quality care:

COMPARATIVE PERFORMANCE OF HMOs ON HEALTH

Prematurity and Mortality

	HMO	*Traditional Mode*
Premature births per 100 live births		
white	5.5	6.0
non-white	8.8	10.8
Infant mortality per 1,000 births		
white	22.7	27.3
non-white	33.7	43.8
Annual mortality of elderly population (18 months or more after plan membership)	7.8%	8.8%

(Data standardized for age, sex, income, residence, and, where appropriate, age of mother.)

SOURCES: Shapiro et al., *American Journal of Public Health* 50 (September 1960) *and* 57 (May 1967).

The shortcomings of HMOs, mentioned earlier, appear to be these: One careful study found that knowledge about HMOs and the predisposition to choose them over alternative systems are greater among older persons who are heads of large families in the mid-range of income groups. In other words, they are people whom one would expect to make the most sophisticated choices. This suggests that effective means of informing consumers should precede the expansion of HMOs among all population groups.

More significantly, other studies have found that some individuals perceive HMOs as impersonal, inconvenient, and require long waiting to get services. They also feel that there is a "clinical" or even a "charity" atmosphere in the health care facilities. Most of these perceptions apply to

alternative forms of care as well—but not all of them, and not so intensely. In short, there may be attitudinal barriers to the rapid expansion of HMOs, which will require a conscious effort to reduce or eliminate.

The Administration's Proposals. During FY 1972, the Administration will use various existing authorities to stimulate the development of HMOs. The authorities include: Partnership for Health, Regional Medical Programs, Health Services Research and Development, Hill-Burton, and possibly others. But new legislative and administrative initiatives will be needed to build up HMO capabilities across the Nation for the general population, and, more importantly, in areas where health care resources are scarce.

The Administration seeks authorities, therefore, to improve the distribution of health care resources by providing operating grants for HMOs in medically underserved areas, to cover some portion of initial operating deficits, and to provide direct loans to public institutions for initial operating deficits. A sum of $22 million has been requested for both purposes. In scarcity areas now served by Neighborhood Health Centers, and similar models, the Administration would seek to have such facilities eventually become part of HMOs.

For grants and contracts with which to plan the development of new HMOs for the general population, the Administration is proposing an obligation of $23 million.

Authority for guaranteeing loans sufficient to generate $300 million in ambulatory facilities, and for operating deficits of private sponsors, has also been requested. In recognition of the higher costs that would be sustained by medical schools in operating HMOs, the Administration seeks $4 million in grants and contracts for this purpose.

The Administration has also requested $15 million in grants to assist the development of new Family Health Centers in scarcity areas, with the view toward converting them into HMOs or HMO-affiliates.

The Administration's plan would also provide for prepayment to public and private HMOs for the care of Indians, as well as for manpower training in HMO settings. Moreover, while experience over the years indicates that HMOs provide high quality of care, the Administration would provide additional checks, as part of a general plan to review for quality of care and for the utilization of resources in all its new proposals. Accordingly, the Administration proposes establishing Professional Standards Review Organizations (PSROs) within the States to determine whether the quality of care meets professional standards, and whether resources are being used efficiently and effectively. They will review both health insurance and HMO

contracts. They will be under the direction of the Secretary of Health, Education, and Welfare, who will also be assisted by a National Professional Review Council in contracting with PSROs. This Council will review the activities of the local PSROs, and publish information on comparative performance. Furthermore, to provide another checkpoint, and in line with the Administration's efforts to improve the planning capability of State and local governments, State and local planning agencies will review and comment on HMO proposals.

With regard to planning, the Administration is examining the interrelationships among State and areawide planning, Regional Medical Programs, health maintenance organizations, and Area Health Education Centers (discussed below) to develop a more rational structure than exists today for the achievement of their overlapping objectives. The Administration is reviewing these alternatives with a view to their legislative base and the opportunities for consolidation.

Finally, the Administration would use the supremacy laws of the Constitution to pre-empt, in connection with Federal insurance programs, those legal barriers that limit the use of allied health personnel or the organizational form of HMOs.

The goals of the Administration are to develop 450 HMOs by the end of fiscal year 1973, 100 of which would serve areas with a scarcity of health care resources. By the end of fiscal year 1976, the plan calls for 1,700 HMOs with the potential of enrolling 40 million people, 10 million of whom would be in families with incomes under $8,000 a year. By the end of the decade, the goal will be to have a sufficient number of HMOs to enroll 90 percent of the population, if they desired to enroll. Most importantly, the choice of traditional modes of care would remain.

In the development of HMOs, as well as in the development of other community services that depend in part upon Federal resources, the Administration is committed to putting together "packages" of resources that are now to be found only in categorical, earmarked pigeonholes. That is, as an action complementing the proposed consolidation of grants, the Administration proposes to enable those seeking to achieve national purposes, but are now impeded and frustrated by the compartmentalization of Federal funding, to negotiate at a single point of access in the Government and with a single instrument for the combination of resources needed to achieve the purposes. The Administration recognizes that while specific problems have their advocates, at the community level the problems are interrelated. The resources that have been available for the specific problems must be reassembled for a realistic and holistic community program.

3. Health Manpower

In the statement of the causes of the "health care crisis," the main problems were identified as: poor distribution of physicians, both in geographic location and in type of practice, poor utilization of our manpower resources, and financial difficulties of our professional schools. Although not contributing to the crisis, there are other problems that a comprehensive manpower strategy should cope with. One is that between now and the end of the decade, the population is likely to increase by 22-27 million people, with a marked increase in the elderly—about 4 million more people over the age of 65 than today. While the number of children under 19 years of age will probably decline by approximately 2 million, thereby freeing some health resources, the increase in the elderly—the group that consumes the largest amount of health services in proportion to their numbers—will more than take up whatever slack is created.

As a consequence of expanded insurance coverage, effective demand for health services is likely to increase. Moreover, both personal income and educational attainment will increase in the decade ahead, and because income and education correlate with demand for health services, we can expect additional demands from this cause.

Finally, in reviewing the enrollments in professional schools by race and sex, the Administration has found that women and members of racial minorities are vastly under-represented in relation to their numbers in the population. In 1969, fewer than 3 percent of all candidates for medical degrees were black, and only 8 percent of all medical students were women. In dental practice at the present time, the figures are only 2 percent in each case. Medical and dental schools are trying to turn this situation around, as evidenced by the composition of their entering classes last year—more than 6 percent black and 11 percent women. But, clearly, more needs to be done.

Using a broader measure—family income—one finds similar results. In recent years, fewer than 10 percent of medical students were from families with $5,000 annual income or less, although such families constitute 25 percent of all families in the Nation.

Thus, providing opportunities for members of racial minorities, women, and students from low-income circumstances to attend professional schools must, in the name of fairness and justice, be included in a manpower strategy.

The Administration's proposals in their entirety come to grips with all of these problems. Indeed, for example, it is firmly convinced that no

reasonable means of improving the distribution of health manpower—the most severe problem—has been rejected.

Improving the Distribution of Manpower Resources. In addition to the improvement in distribution that is anticipated through the development of HMOs in scarcity areas (see preceding section), the Administration proposes a wholly innovative $45 million fund—Health Manpower Educational Initiative Awards—about $40 million of which will be used to create Area Health Education Centers (AHECs) in underserved parts of the country, both urban and rural. These centers will be affiliated with medical schools or university health science centers and will perform the dual function of education in the health disciplines and direct service to the surrounding community.

While a long-range strategy based on HMOs and AHECs is being implemented, the Administration will take immediate steps to supply health manpower in areas of critical shortage. The Emergency Health Personnel Act of 1970 authorizes the Secretary of Health, Education, and Welfare to send doctors, dentists, nurses, and other health workers into scarcity areas, at the request of public or non-profit health agencies and with the approval of State and local governments and district medical societies. A $10 million appropriation for fiscal 1972 will support an initial 600 to 1,000 health personnel in pilot projects.

The Emergency Health Personnel Act is not a permanent solution to the problems of manpower maldistribution—but it represents a useful transition device until the overall Administration strategy takes hold.

To encourage primary care physicians, dentists, and nurses to practice in medically underserved areas, the Administration proposes to forgive $5,000 in loans, plus interest, that physicians and dentists borrow as students, or 25 percent of nurses' loans, for each year served in such areas.

The Administration would offer two other types of incentives to shift the distribution of medical students more towards primary care. At the undergraduate level, preceptorships or clerkships would be established whereby medical students could gain firsthand experience in the practice of primary care medicine. At the graduate level, assistance would be provided for setting up primary care residency programs in the Area Health Education Centers.

In sum, to improve the distribution of health services, the Administration is supporting the formation of HMOs and Area Health Education Centers in scarcity areas, the training of physicians assistants, such as MEDEX, forgiveness of loans for the education of health personnel

according to the type of practice and the location of that practice, special projects for the training of primary physicians and their aides, assistance for technical development and its use (such as closed-circuit TV), and the initiation of an emergancy health service corps. While the Administration cannot guarantee any specific degree of success for these measures, it believes that all reasonable measures have been included, and it will continue to search for new ones.

Improving the Utilization of Health Manpower. As health maintenance organizations develop and spread, the utilization of health manpower will be improved. The ratio of physicians to population in HMO-type organizations today, for example, is approximately 1 to 1,000, in contrast with the average ratio throughout the Nation of 1 to 590, indicating that HMOs use physician services more efficiently.

Beyond the expected accomplishments of HMOs, the Administration would also undertake several other major efforts to improve the utilization of health manpower. These include using present capacity to its utmost and expanding capacity to train physicians assistants, especially those who could be delegated a significant percentage of the tasks of general practitioners, obstetricians, and pediatricians. Programs such as MEDEX, which draw upon the trained cadre of ex-military corpsmen, in conjunction with MEDIHC—an information program used to acquaint military corpsmen of opportunities for civilian health careers—will also be expanded. Opportunities would also be expanded for nurses to become pediatric nurse practitioners, nurse midwives, and public health nurses. Further development of programs to train dentists to use one or more chairside assistants effectively is also envisioned. Somewhat in excess of $26 million would be allocated for these purposes in Fiscal Year 1972.

Another major effort would be to train physicians and dentists, while still in professional school, to work with all the members of their teams and to learn how to use their subordinates efficiently and effectively, thus conserving their own time and skills for the care they can uniquely give. Project grants would be awarded for this purpose.

Special efforts would also be made to bring inactive nurses back into the labor force. There are nearly as many inactive as active nurses, and experiences under several auspices have indicated that some nurses can be persuaded to undertake short retraining courses and then resume their nursing careers.

Technological development also offers opportunities for improving the utilization of scarce manpower skills, while also serving other purposes such as improving the quality of care and the distribution of services. To

illustrate: In Salem, Missouri, under the auspices of a Regional Medical Program grant, a general practitioner's office is linked by computer to a university. Patients who come in for a physical participate in feeding information into the computer, through a process similar to self-instruction teaching machines, and nurses add information from tests they perform. A great deal of information is available to the physician by the time he sees the patient, and his own judgmental decisions are entered into the patient's computer-recorded file. Technology, the use of the patient as a participant in the proeess, and the use of nurses substituting for tasks previously performed by the physician each can contribute to improving utilization. The Administration will continue to support efforts of this nature.

Student Assistance. One objective of thc Administration, as noted earlier, is to enlarge the opportunities of the disadvantaged to enter professional careers. Accordingly, under the Administration's plans, scholarship support would inereasc from $15 million currently to $29 million. The average amount of scholarship assistance for medical, dental, and osteopathic students would triple—going from $1,000 to $3,000. These scholarships would be awarded for the first two years of study, the years in which greatest attrition normally occurs. Students from disadvantaged backgrounds would be expected to borrow, on guaranteed loans, to complete their education, but a speeial provision in the Administration's plan would permit these students to forego payment on thcir loans should they be unable to complete their education. Bccause studies have found that the *thought* of indebtedness deters disadvantaged students from seeking higher education, the Administration proposes to removc this barrier.

For all other students of medicine, osteopathy, and dentistry, guaranteed loans up to $5,000 a year would be available. No student, henceforth, will have to forcgo a professional education because he is unable to gain access to adequatc financing. While the loan indebtedness of the students may appear to be large, several points are to be noted in this regard. First, if the professional schools reducc the length of the curriculum from 4 to 3 years, the student's maximum loan indebtedness would drop from $20,000 to $15,000 for his profession education. Second, the income expeetation of physicians is quite large, and repayment should be relatively easy. Third, the risk for students is quite low—the chances of graduating for an entering student is about 92 percent today, and the percentagc climbs after each succeeding year. Finally, a student who anticipates the maximum indebtedness of $20,000 could cancel his indentedness by entering a primary care field and by practicing in a scarcity area for 4 years.

The Administration has also proposed extending scholarship support for nursing students, whether thcy study in baccalaureate institutions, junior

colleges, or in hospital diploma schools, and increasing the maximum loan guarantee from $1,500 today to $2,500 a year.

Improving the Financial Stability of Health Professional Schools. The Administration proposes a nearly threefold increase in Federal support for basic medical, dental, and osteopathic education. The funds would be provided for students graduated, rather than for students enrolled, and the schools would receive $6,000 for each student graduated (a "capitation" grant). These funds, plus the funds for the special projects mentioned earlier, and Federal funds for other purposes (participation in HMOs, in Regional Medical Programs, and so forth), should relieve most and possibly all of the schools' present financial distress. For a few schools, "emergency" grants may still have to be provided, but the goal is to eliminate "crisis" financing in the near future.

It should be noted that if the health professional schools continue to train students in 4 years, they will receive $1,500 per student each year, but if they shift to a 3 year curriculum, they will receive $2,000 per student. The report of the Carnegie Commission on Higher Education and the Nation's Health (October 1970) estimated that a shift to 3 years would produce potentially a saving of more than a third of the total cost of training physicians and dentists. That would depend, however, on how the schools go about collapsing the curriculum. For the student, the shift would mean a saving of one year's expenditures on his education (again, depending on how the curriculum is shortened), plus the earnings now foregone during the fourth year of training. For the manpower supply, it will mean a one-time bonus of an extra graduating class.

By rewarding the schools for their output—their graduates—the Administration's proposals should also provide incentives for increasing the efficiency of the educational process. It offers an incentive to the schools to fill places vacated by "drop-outs" and to integrate the basic science curriculum of the professional schools with the basic science departments in nearby or parent universities. Attrition is now running about 8 percent of enrollment, or between 800 and 900 medical students. About 250 of these places will be filled by, for example, American students who are studying in foreign medical schools. But the unfilled places—550 to 650—represent the output of five to seven medical schools, which is a costly loss to society.

Increasing the Supply of Health Manpower. While poor distribution and utilization are at the root of our health manpower problems, the Administration's strategy proceeds from the assumption that these problems, for the most part, must be addressed at the margin—in terms of each new increment in manpower—where prospects for success are greatest. Physicians and dentists with established and successful practices in affluent suburbs are

not likely to move to scarcity areas, and they cannot be ordered to move into urban ghettoes or into isolated urual areas. It is also wholly unrealistic to expect an experienced radiologist or pathologist suddenly to switch to primary care. Moreover, although older physicians can and do employ assistants of one kind or another, most of them lack either the inclination or the knowledge to make the fullest possible use of assistants. In each of these instances, it makes far more sense to look to the new professional as the agent for change. Finally, we must plan ahead for changes in population and in the effective demand for services, mentioned earlier, and increase the supply accordingly. The penalty for *not* acting to increase the supply of health manpower could be very high. Therefore, the Administration proposes to use special project grants and construction awards (both grants and guaranteed loans) to increase the supply of health manpower.

Less crucial, but not unimportant in the resolution of the health manpower problems of the Nation, is the assistance the Federal Government can offer to such other health professionals as veterinarians, podiatrists, pharmacists, and optometrists. The Administration has requested new authority to expand educational opportunities in these fields for disadvantaged students, to train new types of health service personnel, to promote preventive medicine, to include them in the team approach to delivering health services, and to improve the distribution of trained personnel in these professions.

Finally, the Administration's manpower strategy calls for a number of related and interlocking actions to improve the use of our manpower resources. The first is an intensive examination and resolution of the problems associated with medical malpractice. The second is to improve the opportunities for upward mobility among individuals in allied health and nursing professions; this will be accomplished by assisting in the development of equivalency examinations to enable these individuals to substitute experience for education. The third is to develop model laws and other procedures by which legal barriers to career development and the efficient use of manpower can be lowered or eliminated.

The Administration has proposed a comprehensive manpower strategy designed to overcome the crucial problems of today, and to prepare for the likely eventualities of the future. The Administration's FY 1972 budget calls for a total of more than $1.1 billion for education and training of health manpower; more than half of this total would be administered by the Department of Health, Education, and Welfare.

4. Improving the Financing of Health Services

The key problems that were identified in relation to the financing of services were: inadequate access to care because of financial barriers,

inadequate benefits for many people who have insurance coverage, and unnecessarily high costs resulting from a mutually reinforcing financing and delivery system. The Administration's objectives, therefore, are to reverse these circumstances—i.e., to increase access to care by lowering financial barriers, to see that insurance coverage provides adequate benefits, and to provide a link between the financing and delivery system so that unnecessarily high costs may be avoided.

The Administration proposes a *national* health insurance program, providing some financial protection for everyone. It is not a *nationalized* health insurance program, for it does not require the Federal Government to assume the entire national health care bill. It is a partnership between the public and private sectors, designed to build upon the durable parts of the existing base of private and public health insurance, and extend coverage to all families with children.

National Health Insurance Partnership Act (NHIP). A substantial majority of American families have some form of health insurance, primarily through employer-employee plans. To extend this coverage to all employed individuals and families that include employed persons, and to ensure that the benefits are adequate, the Administration proposes the National Health Insurance Partnership Act. This Act would require employers to provide basic health insurance benefits for their employees and their families, and to share the costs with them.

Because the employer-employee plan would not meet the needs of families headed by an adult who is not usually employed, and thus ensure adequate protection for "poor" and "working poor" families, the Administration proposes, as a complement to this Act, a Federally-assisted Family Health Insurance Plan (FHIP). FHIP would replace the current Medicaid program for low-income families with children, but Medicaid will continue to provide benefits for the poor who are blind, disabled, and aged.

Medicare will continue to provide protection for the elderly, but the burden of the monthly premiums will be removed through absorption into employee-employer contributions to Social Security.

Under NHIP, every employer subject to the Act will be required to provide approved health insurance coverage for all employees who work more than 25 hours a week, and employees will be able to bring suit in Federal courts to compel compliance with the Act.

To qualify for approval under the Act, employers must offer insurance plans, with the following benefits, to every employee and each member of his family:

—inpatient hospital care;

—physician's visits at home, hospital, office or clinic, including well-child care;

—routine eye examinations for children under the age of twelve;

—maternity care, prenatal and postnatal physician's services, and family planning services;

—emergency ambulatory care, including dental services, for accidental and other injuries; and

—X-ray and laboratory services.

Providers of serviees under these insurance plans will be required to satisfy the conditions of quality control, claims review, and utilization review now required by Medicare. (See also the comments on Professional Standards Review Organizations at the end of the section on health maintenance organizations.)

Every plan must also allow the employee the option of enrolling in a prepaid health maintenance organization—a requirement that forges a link between the financing and delivery systems.

Every employee may be expected to assume a limited share of the financial costs for the medical services used by his family. This share ("deductibles") may not be in excess of the reasonable cost of two days' hospital room and board for hospital inpatient services, plus 25 percent of the remaining cost of such services ("coinsurance"). There would also be a deductible of $100 for each family member, up to three members, for covered medical and other health services, plus 25 percent coinsurance of the remaining cost of such services. When total expenses of an individual reach $5,000, the employee pays no further deductibles or coinsurance, meaning his maximum is about $1,500.

Approved plans must also provide maximum benefits of at least $50,000 per family member over the life of the contract, with $2,000 of the exhausted benefits restored each year. For pre-existing conditions, benefits may not be denied for more than 6 months from the date of the initial coverage, and the plan may contain no such exclusion for maternity care. Coverage must be extended, if the employee so desires, for at least 90 days after his employment has been terminated.

The cost of coverage under the Act would be borne jointly by employers and employees. During a transition period of two and one-half

years, the employer would be required to contribute at least 65 percent of the plan. Thereafter, the minimum employer contribution would be 75 percent. The lower contribution rate in the initial period is intended to ease the burden of adjustment to the new system.

The Administration's proposal would become effective on July 1, 1973.

The Family Health Insurance Plan (FHIP). Poor and near-poor families will be provided with health insurance protection through the proposed Federal Family Health Insurance Plan, FHIP is designed to replace Title XIX of the Social Security Act—popularly known as Medicaid—for low-income families with children. The shortcomings of Medicaid are so great, it has become essential to replace it. These shortcomings include striking variations in the value of benefits to families in similar circumstances residing in different States, and wide variations in benefits, eligibility, and population coverage. Thus, Federal dollars are being distributed very unevenly and inequitably among the low-income population in the program.

Moreover, exclusion of the "working poor" increases the inequities of the existing welfare system, so that half of the ten million poor children in the Nation receive no publicly assisted health services. This discrimination creates two potentially serious side-effects for the family. First, it encourages marital breakup, since female-headed families can qualify for benefits, while male-headed families, in most cases, cannot. Second, it discourages the male head of a family from working by making full benefits available to families headed by unemployed males, while denying similar benefits to those headed by employed males.

A further inequity is that public assistance recipients receive full benefits, at no cost, up to the income at which they leave the welfare rolls. At that point, they lose all benefits. Families whose earnings take them just above the cutoff may therefore be worse off than if they were still on welfare. This abrupt termination of benefits can be a serious barrier to self-sufficiency. Those who are familiar with the Administration's welfare reform proposals will note that the proposed health insurance reforms are meshed with welfare reforms. Moreover, while families would make increasing payments for insurance, their income would be rising under welfare reforms.

The shortcomings of Medicaid suggest that an equitable program of medical assistance for low-income families must meet additional criteria for there to be a fully effective program. It must eliminate geographical inequities, categorical inequities, work disincentives, and ensure adequate protection. It should also promote the development of health maintenance organizations, and foster efficiency in the health sector.

In the Administration's proposal, eligibility for FHIP would be based upon family income, adjusted for family size. Families with incomes up to $5,000 for a family of four (the median size of FHIP families), who do not have health insurance protection through a required employer-employee plan, would be eligible for FHIP. About 5.4 million families with children fall below these income limits, and about 3 million of these would be eligible for FHIP benefits, including mirgrants, domestics, and other part-time workers as well as non-workers. The income limits for family sizes up to seven are shown below.

Family Size	*Income Limit for FHIP Eligibility*
2	$3,400
3	4,200
4	5,000
5	5,800
6	6,400
7	7,000

These income limits were chosen because they include the population with the least adequate private health insurance coverage, and for whom private coverage is unlikely to provide the required protection. While 85 percent of families with incomes above $5,000 have some private health insurance, only 45 percent of those below $5,000 have private coverage. Even in the income range from $5,000 to $7,000, almost 80 percent of all families have some private insurance. The most substantial gap in private coverage exists for families below the $5,000 income level. FHIP is designed to fill that gap for those who do not qualify for mandatory employer-employee insurance under the NHIP Act.

A small fraction of the families above the FHIP eligibility cutoff does not now have private coverage, and an additional number have inadequate health insurance protection. The NHIP Act will provide coverage for most of these families. Employer-employee health insurance will close the gap without displacing the private coverage now enjoyed by the vast majority of families in these higher income brackets, and without imposing a huge expense on the general taxpayer.

Families enrolled in FHIP will be eligible for assistance in meeting expenses for:

—Physicians' visits at home, office or clinic, up to a maximum of eight visits per person per year; this maximum will not apply, however, to visits for prenatal, postnatal, or well-child care, or family planning;

—Maternity eare, prenatal and postnatal physicians' services, well-ehild visits for children below the age of 5 years, and family planning serviees;

—Out-of-hospital laboratory, x-ray and surgery;

—Emergeney ambulatory care within 24 hours of accidental injury; and

—Hospital eare and related physicians' services, up to 30 days per person per year; or the cost-equivalent of hospital care for skilled nursing home services or approved home health services.

All providers of covered services will be subject to the conditions of quality eontrol, elaims review, and utilization review required by Medicare. Families enrolled in FHIP may elect to receive services either from individual providers or from a health maintenance organization. In the latter casc, FHIP will make a direct payment to the HMO, on a capitation basis, equal to average FHIP reimbursements to covered families in thc area.

The specifie package of covered serviccs includes the essential medieal services required for adequate family health care. Outpatient care is covered in order to eneourage the use of preventive and health maintenance serviees that reduce the probability of serious illness and the necessity of prolonged hospital stays. In addition, the inclusion of outpatient services will discourage the use of costly inpatient proeedures when less expensivc outpatient treatment may be substituted.

As explained earlier, the value of benefits under a medical assistance program should decline smoothly as income rises to the eligibility eutoff level, in order to avoid the disineentive effect of an abrupt termination of benefits at that point.

There are two prineipal ways in which the value of eoverage can be reduced as income rises. First, the family may bc required to pay income-related premiums in order to qualify for coverage. Seeond, coverage under the program may require covered families to make deductible and coinsuranee payments, with the size of these payments sealed to family income. FHIP ineludes both forms of family contributions. Since these features are central to the design of FHIP, it is important that they be clearly understood.

The FHIP premium is a periodic payment based solely on family income, regardless of the family's use of medical care. It is directly analogous to premiums paid for private insurance, except that it is scaled to income. (Families covered by FHIP would have their premiums deducted from their assistance checks.) A family of four would pay the following annual FHIP premiums at the indicated income levels:

Family Income	*FHIP Premium*
$0-3,000	$0
3,500	25
4,000	50
4,500	75
5,000	100

In addition to the FHIP premium, the value of benefits would be reduced by income-related deductibles and coinsurance. The FHIP deductible is defined in terms of the number of days of hospital services for which the covered family is financially responsible; both the deductible and coinsurance vary with family income. The deductible and coinsurance provisions for a family of four are shown in the table below.

Family Income	*Hospital Deductible**	*Other Deductible*	*Outpatient Coinsurance***
$0 - 3,000	0	0	0%
3,000 - 3,500	1 day	0	0
3,500 - 4,000	1 day	$50/family	0
4,000 - 4,500	1 day	$50/family	10
4,500 - 5,000	2 days	$100/family	25

*Assessed at average per diem charges for room and board, not actual charges.

**Applied to all outpatient services except maternity and well-child care.

As the table indicates, a family of four with income below $3,000 would pay no deductible or coinsurance. At an income of $4,000, the family would pay for the first day of hospital care used by each family member, a $50 annual deductible and 10 percent of the cost of outpatient care, except for maternity and well-child care. The hospital deductible is assessed at the average daily cost of room and board (currently about $50), rather than actual expenses incurred. Any expenses in excess of the family's deductible and coinsurance liabilities would be reimbursed by FHIP.

Taken together, the FHIP provisions slowly increase the financial liability of a family at the income cutoff for FHIP eligibility to approximately the beginning level under the NHIP Act, so there will be no reduction in benefits, or increase in cost of coverage, as the family loses its FHIP eligibility. Thus, there will be no work disincentive associated with the program.

The cost-sharing charges in FHIP are carefully graduated with income to ensure that they do not present an insurmountable barrier to necessary care, while still being significant enough to discourage excessive utilization of health services. Moreover, the form of the cost-sharing provisions will provide positive incentives for efficient choices among the various types of care and providers. A one-day hospital deductible will discourage the use of high-cost inpatient facilities for proeedures that can be performed as effectively on an outpatient basis. By eliminating the family portion of Medicaid, taxpayers will save $1.8 billion against the total Federal cost, resulting in a net additional Federal cost above Medicaid for FHIP of $1.2 billion.

The States, relieved of responsibility for their share of the family portion of Medicaid, may save as much as $1.8 billion. The States will be encouraged to use a part of this saving to supplement the basic Federal benefit package by providing services not covered by FHIP.

The effective date for the Family Health Insurance Program would be July 1, 1973.

Ensuring Access to Medical Care for Other Groups. Neither the National Health Insurance Partnership nor the Family Health Insurance Program will meet the medical care needs of the elderly, poor adults not living in families with children, and the self-employed. The Administration's health strategy also makes provision for these groups.

First, it proposes to eliminate the premium now charged aged beneficiaries for outpatient protection. This change will save elderly persons an estimated $1.4 billion a year in premium payments, offset in part (by $400 million) in additional cost-sharing. It will be financed by changing Social Security payroll deductions. Second, the Administration proposes that Medicare beneficiaries be enabled to use their coverage to enroll in a health maintenance organization.

FHIP will replace only the family portion of Medicaid. The Medicaid program for adult categories—providing medical assistance for the aged, the blind, and the disabled—will continue unchanged. The Department of Health, Education and Welfare is reviewing this program to see how it might be improved.

In order to ensure that health insurance is available to self-employed persons and unemployed single individuals or couples, the National Health Insurance Partnership Act will require those insurance companies offering employer-employee plans to participate in pools that will make group plans available to any individual or family not eligible for this coverage. Premiums for these group plans will be subject to approval by the Department of Health, Education and Welfare, and the plans will be required to provide the same minimum benefits as employer-employee plans. Although the plans will not be subsidized, individuals enrolled in them will be able to take advantage of savings possible through group coverage. The group plans will also ensure that no one is denied coverage because he is a "poor risk."

Regulation of the Health Insurance Industry. In the past, some insurance carriers have abused their trust by not conveying to the consumer with clarity the coverage and exclusions in his contract. Some have failed to perform claims and utilization reviews, or excluded high risk groups, or cancelled policies suddenly. The Administration proposes to regulate the insurance industry, which is essentially unregulated at this time. Not only will the abuses be prevented in the future, but citizens will have better and cheaper coverage through competition among carriers.

Additional Benefits in the Future. As the economy expands, and additional resources become available for health services, it should be feasible to add benefits to both parts of the National Health Insurance Partnership plan. Among the range of alternative benefits, the most desirable addition that can be foreseen at this time would be for outpatient psychiatric care, prescription drugs, and dental care for children. Besides additional resources for these purposes, we shall also need to develop techniques with which to review and evaluate the utilization of these services, to avoid either under- or over-utilization.

These, then, are the Administration's health insurance proposals. They are national in scope; they draw upon the strengths of both the private and public sectors; they offer the means for correcting past weaknesses. The Administration's plan lowers financial barriers to health care, enlarges the benefits, and affords a number of opportunities for bringing costs within a reasonable range.

Summary of Efforts to Control Medical Costs

The Administration's proposals contain an interrelated set of measures to reduce the inflation in medical costs. The objectives are twofold: to reduce the annual per capita expenditures on medical care, and to reduce the unit cost of providing care.

With respect to reducing the rate of increase in annual per capita expenditures, the relevant proposals of the Administration are those that: emphasize a broad and concerted preventive effort, including the actions that citizens may take on their own to reduce the need for care; the reduction in unnecessary utilization of services through scaled deductibles and coinsurance in the health insurance plans and through co-payments under Medicare; and the availability of low-cost group insurance rates for those people now covered by high-cost individual plans.

With respect to reducing the rate of increase in the unit cost of providing care, the relevant proposals of the Administration are those that: encourage the establishment of health maintenance organizations, with their own built-in incentives for efficiency; strengthen State and local planning capability to rationalize expenditures on capital facilities and other resources; promote the use of physicians assistants and other assistants of physicians and dentists, as well as capital equipment, to substitute less-expensive care without a loss in quality; prospective reimbursement experiments under Medicare; ceilings on physicians' fees; and review for quality and performance by Professional Standards Review Organizations—to reduce unnecessary surgery and the maintenance of under-utilized but expensive facilities (such as seldom-used open-heart surgery teams), as well as improper utilization of health care resources.

While it is impossible at this time to specify the degree to which these anti-inflationary measures will be successful, or their precise effects in reducing the rise in medical costs, they constitute a knitting together of an array of means with which to attack this problem. As other reasonable courses of action present themselves for controlling medical costs, they will be adopted.

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